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ABSTRACT

This unit is designed to help teachers/trainers provide training for respite care providers who may be working with emotionally disturbed persons. The format of the guide includes basic components that form a unit of instruction: objective sheet, instructor's guide, instructor's supplements, information sheet, student supplements, activity sheets, test, and answers to test. The unit components focus on measurable and observable learning outcomes and are designed to be used in more than one lesson or class period. This unit covers three objectives: (1) define terms associated with the care of emotionally disturbed persons; (2) name characteristics of emotional disorders; and (3) describe appropriate behavior management techniques. (KC)

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# RESPITE CARE SERIES

## TEACHER EDITION

# RESPITE CARE FOR EMOTIONALLY DISTURBED

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Oklahoma State Department of Vocational and Technical Education
Stillwater, Oklahoma

HO - 1022

# Advanced Respite Care Emotionally Disturbed

Developed by the
Curriculum and Instructional Materials Center
for the division of Health Occupations
Oklahoma State Department of Vocational and Technical Education
Roy Peters, Jr., Director
**Oklahoma State Board of Vocational and Technical Education**
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## FOREWORD

In 1988 representatives from the Curriculum and Instructional Materials Center (CIMC) of the Oklahoma State Department of Vocational and Technical Education; Positive Reflections, Inc.; Oklahoma Child and Adolescent Service System Program; Oklahoma State Department of Mental Health; and Oklahoma State Department of Human Services met to discuss developing, as a cooperative project, a course of instruction designed for training individuals to provide respite care for emotionally disturbed clients.

This publication is the result of those original discussions and close coordination among parents, government agencies, volunteer groups, and educators. *Advanced Respite Care: Emotionally Disturbed* is one of the publications from the Respite Care series of competency-based training programs designed to coordinate the practical experience and knowledge needed by personnel working in respite care.

Although this series reflects a systematic approach to instructional materials development and the latest in educational technology innovations, the instructor should adapt and modify information in *Advanced Respite Care: Emotionally Disturbed* to coincide with local conditions and specific student/client needs.

ROY PETERS, JR.
State Director

## PREFACE

For many years the Oklahoma State Department of Vocational and Technical Education has recognized the need for providing quality competency-based instructional materials for vocational education. Oklahoma has met the challenge by providing nationally recognized curriculum and services since 1972.

In 1988 Oklahoma's Curriculum and Instructional Materials Center (CIMC) determined a significant need for a series that would address training needs for respite care providers working with special needs clients of all ages. *Basic Respite Care* requires students to show proficiency in the basic skills and knowledge necessary for employment as a respite care provider working with special needs clients. *Advanced Respite Care: Emotionally Disturbed* provides advanced-level training for care providers who want to work with emotionally disturbed clients who require specialized care. A student will not be certified as a trained respite care worker eligible to work with emotionally disturbed persons without first receiving certification in Basic Respite Care.

At the meetings to define the training, many committee members expressed concern about the qualifications needed to be a respite care provider. In addition to the caring, professional attitude that is highly desirable for these workers, committee members expressed the need for the provider to be bondable (this implies that an application must be completed whether or not the actual bonding takes place) and to be cleared through the Social Rehabilitation Services for any charges of child abuse. The screening process for students may also consider local agency requirements. Students who are not bondable could still take the course but would not be eligible for certification; the screening process should make students aware of the situation before the course begins. The screening process may need to be repeated and updated when a student applies for the advanced courses.

The program is intended to be available to all agencies in Oklahoma to provide training for respite care providers who may be working with emotionally disturbed persons. The goal of this program is to provide qualified, caring individuals to work with special needs clients and to have all care providers demonstrate the competencies outlined in this program before placement with a client.

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## ACKNOWLEDGEMENTS

Thank-you goes to the following ad hoc committee members who contributed their time, talents, and knowledge in determining the content of this manual:

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A special thank-you goes to Richard Donner, Barbara Huff, Fran Morris, and Mary K. Rodwell for their special contributions to the instructional materials.

Thank-you also goes to the staff of the Oklahoma State Department of Vo-Tech, to Dr. Roy Peters, Jr., Director, to Dr. Charles O. Hopkins, Assistant State Director, and to Sheila Stone and Greg Pierce, who led the curriculum staff during the development of *Advanced Respite Care: Emotionally Disturbed.*

Betty Duncan, R.N., Director of Vocational Nursing, Vernon Regional Junior College, Wichita Falls, Texas; and Jerry Weir, Technical Writer, wrote this manual. Brenna Tillman did the word processing. Michelle Sharp, Publications Design Specialist, prepared the final version.

## USE OF THIS PUBLICATION

### INSTRUCTIONAL UNIT

The format of *Advanced Respite Care: Emotionally Disturbed* includes basic components that form a unit of instruction: objective sheet, instructor's guide, instructor's supplements, information sheet, student supplements, activity sheets, and test. The unit components "zero in" on measurable and observable learning outcomes. When applicable, the unit includes activities that use the affective domain. Instructors may supplement, personalize, localize, and motivate with these materials to develop a complete teaching/learning process.

Designed to be student centered and instructor facilitated, each unit of instruction is for use in more than one lesson or class period. Through the individualized study guide and the pretest, a student may receive credit for prior knowledge and experience. The instructor's guide presents teaching suggestions for use in either group or individual study.

The instructor will need to decide methods of presentation and demonstration to meet the needs of students. Careful study of each unit of instruction will help the instructor plan the presentations:

- How to use materials for independent study
- Amount of material to cover in each class period
- Skills — Supplies and equipment needed
  Amount of class time needed for demonstrations
  Amount of practice needed
- Supplementary materials, such as pamphlets or videos, to order
- Resource people to contact

**Objective** Sheet (white pages)

Each unit of instruction is based on the knowledge and skills needed for successful employment in an occupational area. Objectives are stated in two forms: unit objective stating the subject matter to be covered in a unit of instruction, and specific objectives stating the performance necessary to reach the unit objective. Because the objectives of the unit provide direction for the teaching/learning process, teachers and students must have a common understanding of the intent of the objectives. Each student should have a copy of the objective sheet to refer to throughout the teaching/learning process. This will help answer any questions concerning performance requirements.

The objectives can also help determine teaching strategies and instructional methods. Prepare for each unit by deciding how each objective can best be taught, depending on individualized or class instruction. Instructors should feel free to modify, delete, or add

objectives to meet the needs of the students and community. If there are changes in the objectives, the instructor should supply the additional information, assignment, procedure, or activity sheets, and criterion test items.

**Instructor's Guide** (white pages)

The instructor's guide contains a list of the unit contents, suggested activities for individualized and group instruction, and unit resources.

The suggested activities include a guide to help instructors plan their presentation of the unit. Reading the suggested activities before teaching the unit allows time to obtain supplemental materials and audiovisuals and to contact outside resources. Instructor duties will vary according to whether the material is to be presented to a group or individualized.

References listed in the instructor's guide are those used in the development of the unit. The instructor may use the references to supplement knowledge of the subject area or to guide students with particular interests or occupation objectives in the area covered.

**Instructor's Supplements** (white pages)

This component includes the pretest, answers to pretest, and individualized study guide, material that would be utilized by the instructor to prepare for teaching the unit. The pretest helps meet the needs of individual students. Through the pretest, students can receive credit for previously gained knowledge or skills that meet the criteria or standards for quality and then use that instructional time to gain new information and skills.

**Information Sheet** (green pages)

The information sheet provides "must know" content essential for meeting the objectives of the unit. The information is keyed to the specific objectives. Boxed items contain "nice-to-know" information and are not on the tests. The information sheet may also include "Notes", "Cautions," or "Warnings"; discuss these carefully and thoroughly.

Notes are short verbal additions to the information sheet that provide nice-to-know and decision-making information. A note may tell the student what to watch for or to consider at a given step. It may explain when a step may not be applicable. Notes offer guidance that may help the student understand the process and do it more efficiently.

Cautions are advisories that tell how to avoid damage to equipment or facilities.

Warnings are advisories that tell the student how to avoid personal injury or death to the student, client, or other persons in the workplace.

**Student Supplements** (green pages)

Student supplements include material that provides additional information for understanding the topic but does not have direct application to specific objectives.

**Assignment Sheet** (tan pages)

Assignment sheets provide written exercises for instruction and practice of a specific objective. The introduction to the assignment sheet explains how the assignment sheet relates to the subject area and unit objectives and may provide instructional information or refer students to another component for such information.

Assignment sheets are intended to provide students with practice in exercising higher-order thinking skills. Often, assignment sheets will contain case studies or story problems or other situations in which the student must analyze the circumstances and determine correct responses.

**Activity Sheets** (tan pages)

The purpose of activity sheets is to provide activities not directly in support of any one objective but that support several objectives or seek to influence the student's beliefs, attitudes, or appreciation of the study area.

Activity sheets vary greatly in their number and design. Some deal with the student attitudes and beliefs. These are not intended for review by anyone other than the student. Some activity sheets require the student to make written or oral reports.

**Tests** (yellow pages)

The test provides criterion-referenced evaluation on every objective listed in the unit of instruction. The instructor may individualize the test as needed.

**Answers to Tests** (pink pages)

Answers to tests assist the instructor in evaluating student performances. The student must achieve 80 percent on each written objective to pass the unit. A score of 80 percent overall is not acceptable. The student must prove competency in each objective.

## METHODS OF DISSEMINATING MATERIAL

For best results, provide student materials for each student. Student materials contain everything but the instructor's supplements and answers to the test.

## TEACHING METHODS

Keeping students motivated is a challenge. Supplement the objectives by providing the "why," personal experiences, and current information. If you are going to teach the material in a group setting, prepare for the unit by deciding the best way to teach each objective and allow for student input.
If you are going to follow the plan for individualized instruction, provide opportunities that will allow each student to become involved in planning for and being responsible for his or her own education.

## COMPETENCY PROFILES

A competency profile is available for each CIMC publication. Competency profiles document student performance. The profile contains a list of the specific job competencies that a student should achieve before leaving the training program. Profiles should be distributed to students as required.

## CORRECTIONS AND SUGGESTIONS

The Curriculum and Instructional Materials Center (CIMC) wants to provide vocational instructors and students with materials that are accurate and effective. Although the CIMC strives to maintain the highest standards of development and production, oversights occasionally do occur. If you find any errors in this or other CIMC publications, or have suggestions for improving their usefulness in vocational programs, please notify the CIMC staff. One easy way of pointing out errors is to make a photocopy of the affected page and to indicate the correction on the copy. Mail this information to the CIMC, where it will be used to correct the publication before the materials are reprinted.

To ensure that the material is updated on a timely basis, notify the CIMC of necessary corrections as soon as possible after discovering the error. Do not assume that someone else will notice the error and inform the CIMC; other users may be making the same assumption. Please send corrections and recommendations for improving this publication to the following address:

Curriculum and Instructional Materials Center
Oklahoma State Department of Vocational and
Technical Education
1500 West Seventh Avenue
Stillwater, Oklahoma 74074-4364

| OBJECTIVE SHEET | ADVANCED RESPITE CARE<br>EMOTIONALLY DISTURBED |
|---|---|

**INTRODUCTION**

You already know the basics of providing respite care for some clients, and you know that the needs of each client you care for may vary greatly. This also holds true for emotionally disturbed clients. Caring for the emotionally disturbed client can be a very rewarding experience, but it can also be a very frustrating one.

In order to give safe care to emotionally disturbed clients, you must understand their conditions and be aware of any special needs they may have. This unit will give you information on the most common emotional disorders, behaviors, and appropriate care.

**UNIT OBJECTIVE**

After completing this unit, you should be able to provide care for emotionally disturbed clients.

**PREREQUISITES**

Before studying this unit, you should have successfully completed *Basic Respite Care* and should have completed de-escalation or non-violent restraint training (such as CAPE or MANDT).

**SPECIFIC OBJECTIVES**

After completing this unit, you should be able to

1. Match to their correct definitions terms associated with care of emotionally disturbed persons.
2. Name characteristics of emotional disorders.
3. Describe appropriate behavior management techniques for emotionally disturbed clients.

**UNIT CONTENTS**

- Objective sheet
- Instructor's guide
- Instructor's supplements

  Supplement 1 — Pretest

  Supplement 2 — Answers to Pretest

  Supplement 3 — Individualized Study Guide
- Information sheet
- Student supplements

  Student Supplement 1 — General Care Guidelines

  Student Supplement 2 — From the View of the Child

  Student Supplement 3 — Barb's Story: A Parent's Experience

  Student Supplement 4 — Recognizing Cultural Differences
- Assignment Sheet 1 — Describe Appropriate Behavior Management Techniques for Emotionally Disturbed Clients
- Answers to assignment sheet
- Activity sheets

  Activity Sheet 1 — Participate in an Observation Practicum

  Activity Sheet 2 — Participate in a Buddy-System Practicum

  Activity Sheet 3 — Participate in a Hands-on Practicum
- Test
- Answers to test

**SUGGESTED ACTIVITIES**

- **Review unit and plan presentation.**

  1. Study the specific objectives to determine those you will cover in your presentation. Decide also which objectives will be taught to which students.

  2. Determine scope and sequence of objectives that you add. Design and develop support materials, including evaluation techniques, for additional objectives.

  3. Make arrangements for guest speakers.

     - Invite a professional in the field to discuss emotional disorders and techniques for care.

     - Invite the parent of an emotionally disturbed child to talk to the class about routine and crisis care for that client.

     - Invite the parent of an emotionally disturbed adult to discuss routine and crisis care for that client.

     - Provide each speaker with Information Sheet and a specific format of areas to discuss.

  4. Make arrangements for practicums.

     Have a workshop for the people who will participate as "buddies" in the buddy-system practicum. Explain their role and what you and the students expect of them in this phase of the practicum.

- **Obtain materials needed to supplement unit.**

  1. Films, videotapes, and other media

     **NOTE:** Contact local support groups or chapters of national organizations such as The National Society for Children and Adults with Autism for information on current media that may be applicable to specific clients.

  2. Contact your local Department of Human Services, Developmental Disabilities Services, for information about the "Circles" program.

3. Competency profiles

   **NOTE**: Competency profiles for this book are available from the Curriculum and Instructional Materials Center, Oklahoma State Department of Vocational and Technical Education, 1500 West Seventh Avenue, Stillwater, OK 74074-4364.

- **Individualize instruction as required.**

  1. Modify presentation to accommodate special-needs students.

  2. Plan presentations to take advantage of student learning styles.

  3. Provide students with objective sheet and individualized study guide form.

  4. Pretest qualifying students: administer pretest and interview students to assess competencies.

  5. Determine individual study requirements from pretest results.

  6. Counsel students individually on pretest results and study requirements.

     a. Modify materials in unit or create supplementary materials for individual students as required.

     b. Review suggestions for group presentation; modify them and incorporate them into individual study plans as appropriate.

     c. Indicate assignments or activities on the study guide; include media.

     d. Return individualized study guides; provide students with supplementary materials, including LAPs if used.

     e. Set up completion requirements and tentative schedule for next evaluation.

7. Monitor student progress and adjust assignments and teaching approaches as required.

8. Evaluate and document student skills.

   a. Document completion of training for successful students, and direct them to next study area. Complete competency profiles if used.

   b. Retrain and re-evaluate unsuccessful students.

   c. Counsel students who are unable to complete the unit satisfactorily, and make recommendations for continuing study.

- **Provide group instruction as required.**

  1. Introduce unit by discussing unit introduction.

     - Describe briefly some behaviors that might be seen in a client with an emotional disorder.

     - Discuss the increase in teenage suicide; describe the stressors that might precipitate this increase.

     - Review techniques of behavior management, referring to "Develop Behavior Management Skills" in *Basic Respite Care*.

  2. Discuss information sheet.

     a. Discuss Objective 1, terms related to care of emotionally disturbed persons.

        - Have students read Student Supplement 1.

        - Review potential safety hazards found in most homes; review safety factors room by room.

        - Have the students role-play using communication techniques in a variety of situations.

        - Demonstrate components of nonverbal communication.

- Discuss the "circles" concept of recognizing that most people are comfortable with having only close friends and family in close proximity (an "inner circle" with a small radius) but having strangers and acquaintances remain further away physically (circle with a larger radius).

- Have students complete Assignment Sheet 1. Discuss responses in class.

b. Discuss Objective 2 on emotional disorders.

- Have a professional in the field discuss emotional disorders and techniques for care.

- Show a film or tape on substance use/abuse, preferably one that deals with young people.

- Have students read Student Supplements 2 to 4 and complete Activity Sheet 1.

c. Discuss Objective 3 on appropriate ways of handling client behavior.

- Point out that play therapy is a tool for helping build a child's self-esteem when such play occurs in a caring, reassuring, supportive environment. The child gets to play with "messy" materials such as clay, paint, or water while being closely supervised. The role of a respite care provider may include providing opportunities for such play.

- Have a parent of an emotionally disturbed child discuss routine and crisis care for that client.

- Have a parent of an emotionally disturbed adult discuss routine and crisis care for that client.

- Compare the types of care needed by emotionally disturbed children and that needed by emotionally disturbed adults.

- Set up role-playing situations to allow students to demonstrate their communication skills.

EXAMPLES:

A mistake caused by cultural differences

A shy, withdrawn, distant child rushed by an adult

"Battered parent," one who has been told by every agency that the parent has approached the child and the child's problem all the wrong ways

An overstimulated client who may not have enough maturity to avoid more stimulating activities

A talkative, aggressive parent

"Helpless child" who never has been allowed to struggle, who has been "helped" through every difficult situation by a parent

- Relate crisis intervention to the students' practicum experience.

- Remind students of the behavior management process outlined in "Develop Behavior Management Skills": prevent, assess, choose a technique, follow through, document. Apply that process to behaviors mentioned in case studies of this unit.

3. Have students complete Activity Sheets 2 and 3.

   - Discuss the students' comments on the activity sheets; actively involve the students in the discussion.

4. Give test.

5. Reteach and retest as required.

6. Complete appropriate section of competency profiles.

- **Review individual and group performance to evaluate teaching methods. Adjust scope, sequence, or instructional approaches for additional lessons as required.**

## UNIT REFERENCES


Barry, Patricia D. *Mental Health and Mental Illness*, 3rd ed. Philadelphia: J.B. Lippincott, 1985.

Champ, Laurna. *Helping Children with Special Needs Caregiver Book: Level 4*. Stillwater, Oklahoma: Oklahoma State University, 1986.

*Diagnostic and Statistical Manual of Mental Disorders III-R*, 3rd rev. ed. Washington, D.C.: American Psychiatric Association Press, Inc., 1987.

Donner, Richard. *Rest A Bit*. Topeka, Kansas: Rest A Bit of Families Together, Inc., 1988.

Kalman, Natalie and Claire Waughfield. *Mental Health Concepts*, 2nd ed. Albany, New York: Delmar, 1987.

Shives, Louise R. *Basic Concepts of Psychiatric-Mental Health Nursing*. Philadelphia: J.B. Lippincott, 1986.

**SUPPLEMENT 1** **Pretest**

**PART I**

Match the terms to their correct definitions. Write the correct numbers in the blanks. Definitions continue on the next page.

1. Affect
2. Aggression
3. Behavior
4. Coping mechanisms
5. Coprolalia
6. Delusion
7. DSM III-R
8. Echolalia
9. Emotion
10. Emotionally disturbed
11. Hallucination
12. Hyperactive
13. Illusion
14. Incontinence
15. Organic
16. Phobia
17. Psychotherapy
18. Regression
19. Syndrome
20. Tic

___ a. Offensive, harmful action or behavior

___ b. A combination of symptoms that occur together so commonly as to form a distinct clinical picture

___ c. Localized, involuntary movement of a muscle group, especially in the face

___ d. A fixed, unreasonable belief

___ e. The way a person acts or performs

___ f. Methods a person uses to deal with stress or anxiety

___ g. Emotional expression, a mood

___ h. A feeling

___ i. A false perception of an external stimulus, usually seen or heard

___ j. An irrational fear

___ k. Offensive, obscene language that is compulsive and stereotyped; usually relates to feces

___ l. Inability to control the bladder or bowels

___ m. Techniques for treating mental illness that rely on establishing communication between therapist and client

___ n. A manual published by American Psychiatric Association that lists the official diagnostic criteria for mental disorders

___ o. Stereotyped repetition of another person's words or phrases

___ p. A sensory perception that has no external stimulus that can affect all senses

___ q. Having a high degree of emotional difficulty that usually extends over a long period of time

___ r. Pertaining to a body organ or organs

___ s. Retreating to a former level of behavior

___ t. Having an abnormally high level of activity

**PART II** After reading the following situations, determine what disorder the client probably has, based on the information given. Write the name of the disorder in the blank.

_____

**Case 1** David is a fifteen-year-old assigned to your care. Arriving at the house, you are introduced to David. He is sitting in a chair with his head down. He does not respond when you speak to him, he does not move, and he looks sad. His parents tell you that for the past two days, he has not said much and has moved very little. Last week, however, he was constantly on the go and talked nonstop. What disorder may David have?

_____

**Case 2** Jennifer is two years old, and this is your first visit. Her parents explained that Jennifer does not speak and that you should interfere with her as little as possible. All morning Jennifer constantly held a piece of string. She did not speak except when you asked her how she was; for twenty minutes, she repeated what you said. It is now lunchtime. You take the string from her; but she shrinks from your touch, starts to scream, and will not stop. What disorder may Jennifer have?

_____

**Case 3** James is fifteen. He was in a car wreck ten months ago and was hospitalized for two months. When you talk to him, he seems disoriented and keeps telling you there are snakes in the room crawling up the walls. What disorder may James have?

_____

**PART III**

Select two of the following behaviors. Give a short description as to how you would care for a client with each selected behavior. Write the descriptions in the blanks.

Negative
Regressive
Aggressive
Hyperactive
Compulsive

1. Behavior — _____

_____

_____

_____

_____

_____

_____

_____

_____

2. Behavior — _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**SUPPLEMENT 2** — **Answers to Pretest**

**PART I**

| | |
|---|---|
| a. 2 | k. 5 |
| b. 19 | l. 14 |
| c. 20 | m. 17 |
| d. 6 | n. 7 |
| e. 3 | o. 8 |
| f. 4 | p. 11 |
| g. 1 | q. 10 |
| h. 9 | r. 15 |
| i. 13 | s. 18 |
| j. 16 | t. 12 |

**PART II**

Case 1: Bipolar disorder

Case 2: Autism

Case 3: Organic disorder

**PART III**

Negative:
Eliminate chance of negative choices.
Try to make client aware of behavior that needs to be changed.
Encourage client to talk about his or her feelings about the behavior.
Encourage steps toward improvement.
Use reinforcers for appropriate behaviors.
Observe closely for any improvement.
Always show consistency with client.

Regressive:
Establish trust with client.
Always keep promises.
Try to help improve client's self-esteem.
Provide physical care as needed.
Have a structured, controlled environment with as little change in the daily routine as possible.
Let client be as independent as possible.
Do not punish client for failures.
Encourage any improvement.

Aggressive:
Maintain a quiet, calm, and firm approach.
Avoid close body contact that may intimidate or threaten the client.
Set limits for behavior, and give explanations for rules.
Request rather than demand.
Allow clients to express themselves.
Try to get client aware of the problem.
If a specific situation has caused the problem, eliminate it if possible.
Channel aggression into an acceptable outlet.
Isolate the client if necessary.
Use physical containment as a last resort.

Hyperactive:
Be quiet, kind, and firm in your approach.
Make the environment as nonstimulating as possible.
Discourage visitors.
Provide frequent small meals with finger foods to maintain food intake.
Increase client's fluid intake.
Assist with client's physical needs if necessary.
Allow clients to express themselves; do not argue.
Avoid physical restraint.
Involve client in activities that span only a short period of time.
Set limits and explain them to the client.

Compulsive:
Do not interrupt the compulsive activity, but try to divert client's attention to activities client enjoys.
Develop a schedule that includes but reduces frequency of the act.
Spend time with the client to divert his or her attention from the repetitive act.
Allow client to verbalize feelings; try to focus communication on the problem.
Encourage new behaviors and praise small improvements.
Keep in mind that client will have poor judgment.
Maintain close communication with the caregivers; discuss all aspects of the client and concerns with your supervisor, reporting even minor changes.

SUPPLEMENT 3

## Individualized Study Guide

INTRODUCTION

This guide outlines a program of study to meet your individual needs. After you have read the objective sheet for this unit, you will complete a pretest. The objective sheet will tell you what you should know and be able to do as a result of studying this unit. The pretest will tell your instructor how much you already know about emotionally disturbed clients.

There is no grade given for the pretest. It is used only to identify those objectives that you have already mastered and do not need to study. Therefore, you need to complete only those activities marked with a check on this individualized study guide.

| Req. | Comp. | |
|---|---|---|
| _____ | _____ | **Read** objective sheet. |
| _____ | _____ | **Complete** pretest. |
| _____ | _____ | **Discuss** pretest results and study requirements with your instructor. |

OBJECTIVE 1

| | | |
|---|---|---|
| _____ | _____ | **Study** Information Sheet. |
| _____ | _____ | **Read** Student Supplement 1. |
| _____ | _____ | **Complete** Assignment Sheet 1. |

**NOTE:** To check for competency in this objective, the test will present a list of 20 terms that you must match with their correct definitions. To show mastery in this objective, you must make the correct choice for 16 of the 20 terms.

| | Req. | Comp. | |
|---|---|---|---|
| **OBJECTIVE 2** | _____ | _____ | **Study** Information Sheet. |
| | _____ | _____ | **Read** Student Supplement 2. |
| | _____ | _____ | **Read** Student Supplement 3. |
| | _____ | _____ | **Read** Student Supplement 4. |
| | _____ | _____ | **Complete** Activity Sheet 1. |

**NOTE:** To check for competency in this objective, the test will present five case studies of clients who are emotionally disturbed. You will be asked to name characteristics of each client's disorder. To show mastery in this objective, you must correctly name characteristics of 4 of the 5 disorders given.

| | | | |
|---|---|---|---|
| **OBJECTIVE 3** | _____ | _____ | **Study** Information Sheet. |
| | _____ | _____ | **Complete** Activity Sheet 2. |
| | _____ | _____ | **Complete** Activity Sheet 3. |

**NOTE:** To check for competency in Objective 3, the test will present five case studies of emotionally disturbed clients. You will be asked how you would provide care for those clients. To show mastery in this objective, you must describe appropriate behavior management techniques in 4 of the 5 cases.

| | | | |
|---|---|---|---|
| **UNIT REVIEW** | _____ | _____ | **Review** unit and assignments. |
| | _____ | _____ | **Complete** test. |
| | _____ | _____ | **Discuss** test results with your instructor. |
| | _____ | _____ | **Complete** additional study requirements listed below. |

_____

_____

| INFORMATION SHEET | ADVANCED RESPITE CARE<br>EMOTIONALLY DISTURBED |
|---|---|

OBJECTIVE 1

**Match to their correct definitions terms associated with care of emotionally disturbed persons.**

- **Affect** — Emotional expression; a mood
- **Aggression** — Offensive, harmful action or behavior
- **Behavior** — The way a person acts or performs
- **Coping mechanisms** — Methods a person uses to deal with stress or anxiety
- **Coprolalia** — Offensive or obscene language that is compulsive and stereotyped; it usually relates to feces
- **Delusion** — A fixed, unreasonable belief

  EXAMPLE: A client who has a paranoid delusion may think that everyone is trying to poison him or her.

- **Diagnostic and Statistical Manual III-R (DSM III-R)** — Manual published by the American Psychiatric Association that lists the official diagnostic criteria for mental disorders
- **Echolalia** — Stereotyped repetition of another person's words or phrases
- **Emotion** — A feeling

  NOTE: An external expression of emotion is *affect*.

- **Emotionally disturbed** — Having a high degree of emotional difficulty that usually extends over a long period of time
- **Hallucination** — A sensory perception that has no external stimulus and can affect all the senses
- **Hyperactive** — Having an abnormally high level of activity

- **Illusion** — False perception of an external stimulus, usually seen or heard

  EXAMPLE: A spot on a wall may look like a bug.

- **Incontinence** — Inability to control the bladder or bowels

- **Organic** — Pertaining to a body organ or organs

- **Phobia** — An irrational fear

  EXAMPLE: Exposure to an object such as dirt, or a situation such as flying, causes anxiety.

- **Psychotherapy** — Techniques for treating mental illness that rely on establishing communication between the therapist and client

- **Regression** — Retreating to a former level of behavior

  EXAMPLE: An adult who has a tantrum is *regressing*.

- **Syndrome** — A combination of symptoms that occur together so commonly as to form a distinct clinical picture

- **Tic** — Localized, involuntary movement of a muscle group, especially in the face

  NOTE: Tics may be related to stress and anxiety.

**OBJECTIVE 2** — **Name characteristics of emotional disorders.**

## BEHAVIORAL DISORDERS

### ATTENTION-DEFICIT DISORDER WITH HYPERACTIVITY

Causes may be genetic such as an abnormality of cortex of the brain, an organic brain disorder, or stressful family relationships. Onset of the disorder is usually before seven years of age.

Characteristics

- Short attention span
- Inability to complete tasks
- Impulsive acts
- Inability to sit still
- Hyperactivity, with restlessness and constant movement, requiring constant supervision

### CONDUCT DISORDER

Causes may include a lack of bonding after birth, a feeling of being rejected by parents, an insecure home life, poor discipline, poor interpersonal family relationships, or peer influence. This condition is called an *antisocial disorder* if it is diagnosed in someone who is over eighteen years old.

Undersocialized, aggressive type

- May injure others or destroy property
- Cannot develop relationships with others or show affection

Undersocialized, nonaggressive type

- May be disobedient, break rules, lie, show sexual behavior, run away from home, or abuse drugs or alcohol
- Cannot develop relationships or show affection

Socialized, aggressive type

- May injure others or destroy property
- Can develop positive interpersonal relationships

Socialized, nonaggressive type

- Lies, breaks rules
- Can develop positive interpersonal relationships

## NEUROLOGICAL DISORDERS

These disorders are mentioned in a section dealing with emotionally disturbed persons because if the client does not have good coping mechanisms, emotional problems can occur. Children with epilepsy, for example, may be treated as outcasts by their peers. A teenager with epilepsy may not be able to drive, and fear of having a seizure may make dating very stressful. Behavioral problems may arise.

### GILLES DE LA TOURETTE'S SYNDROME

This syndrome develops in childhood, worsens in adolescence.

Characteristics

- Tics, facial grimaces, and involuntary arm movements that can progress to movements in any part of the body
- Possible shouting and grunting, coprolalia, and echolalia

### FETAL ALCOHOL SYNDROME

Alcohol consumed by the mother while pregnant can affect the unborn child, causing minor to severe physical and mental abnormalities. The higher the intake of alcohol, the greater the risks.

Characteristics

- Mental retardation
- Small head
- Hyperactivity
- Webbed toes and fingers
- Poorly developed extremities
- Cardiac defects

### EPILEPSY

Epilepsy is not a specific disease, but rather a group of symptoms caused by abnormal electrical activity of the brain. Usually the younger the age of onset, the more severe the symptoms. This is a seizure disorder; the most common types are *petit mal* seizures and *grand mal* seizures. Medications called *anticonvulsant drugs* can control most seizures.

Petit mal seizure characteristics

This type usually affects children between five and twelve years old.

- A sudden brief loss of consciousness
- Appearance of daydreaming or staring
- Possible facial twitch

Grand mal seizure characteristics

- General involuntary muscular contractions and jerking of extremities
- Teeth clamp together
- Client falls to the ground
- Blue appearance to face because client stops breathing for a short period of time
- Possible incontinence

**ORGANIC DISORDERS**

Organic disorders are mental or emotional problems caused by abnormality or destruction of brain tissue. The specific cause can be a trauma (head injury), disease (high fever), substance use, or a prescribed drug therapy. Depending on the cause, symptoms may be permanent or temporary. Treatment depends on the cause and symptoms.

**WARNING**

Remember that suicide is always a possibility for a client with depression. Some drugs prescribed for organic disorders cause very erratic behavior, and the client may become violent and irrational.

Characteristics

- Memory impairment, disorientation, poor thought processes
- Lack of affect or inappropriate affect
- Apathy, depression, euphoria, withdrawal, aggression, regression, hyperactivity
- Illusions, delusions, hallucinations, anxiety, paranoid behavior, and phobias

**SUBSTANCE USE DISORDERS**

This is a major problem in our society, and is frequently seen in young people. Children often obtain harmful substances such as alcohol and many prescription drugs from their homes. There are many reasons—such as social pressure or escape from the conflicts of reality—why young people take harmful drugs or other substances. Such abuse spans all sections of society and can occur in any age group, even in children as young as eleven years old.

There are two types of dependence: physical and psychological. Physical addiction means the body craves the substance, and there are physiological symptoms if the person stops using the substance. A person who is psychologically addicted thinks that he or she cannot do without the substance.

Substance abuse

*Substance abuse* is taking a substance even while being aware that it is harmful. Continuous use of a particular substance can interfere with social and occupational performance.

Substance dependency

A dependency is more serious than abuse. Not taking the substance causes withdrawal symptoms.

**WARNING**
Depending on the substance, withdrawal symptoms can be severe. A client could die during the withdrawal period.

Alcohol

Alcohol is the most common substance of abuse, probably because of its easy availability and social acceptance. A tolerance for alcohol develops, which means that the amount of alcohol consumed must increase to get the same effect.

Generally, an abuser's peer group will also use the substance. A school-age client may be in trouble at school for truancy. The client may become violent after drinking, and may be in trouble with the law for disturbing the peace or driving while intoxicated. Eventually the client's health and family relationships deteriorate.

Treatment is aimed at managing periods of intoxication and helping the abuser avoid alcohol. A person who has a drinking problem but wants to "kick the habit" must first recognize the problem and be willing to be helped.

Barbiturates or hypnotics

These are sedatives, such as the commonly used Valium and Librium. They depress the central nervous system and are often medically prescribed. These drugs tend to be readily available because they are so often prescribed. They are the leading cause of accidental poisoning, and are often used in suicide attempts.

Abusers of barbiturates usually cannot deal with stress or anxiety. These sedatives can cause physical as well as psychological dependence. Some of the effects are euphoria, relaxation, sleep, and loss of coordination. The drug must be gradually withdrawn from someone who is dependent; sudden withdrawal can cause death.

**Opiates**

Opiates are narcotic drugs used to relieve pain. Heroin is also included in this group, but there is no medical use for it. Physical and psychological addiction occurs. Increasing tolerance of the substance requires increasing doses to achieve the same effect. Withdrawal sickness can be unpleasant and dangerous.

**Amphetamines and related stimuli**

These drugs stimulate the central nervous system, making the user feel more self-confident and alert. Often referred to as *speed*, they can be harmful as they may lead users to do things beyond their physical capacities.

Sudden withdrawal can cause depression, which may lead to a suicide attempt. After repeated use, a drug psychosis may cause hallucinations and delusions. Cocaine is included in this group. These drugs are taken orally, injected into a vein, smoked, or inhaled. Nicotine and caffeine are considered to be stimulants.

**Marijuana (cannabis)**

Marijuana is a popular drug of abuse, usually smoked. It may not be physically addictive, but it is addictive psychologically. Recent evidence shows it can be dangerous. This drug causes euphoria and in large doses can cause depression, hallucinations, and paranoia.

**NOTE:** There is no medical use for marijuana at this time, but there have been studies for its use with cancer patients and glaucoma patients.

**Care for Substance Abusers**

Be aware that people taking hallucinogens may be violent while taking the drug.

Try to build up the client's self-esteem; substance abusers usually have a low opinion of themselves.

Be aware that the client may use manipulative behavior.

If you suspect a client of substance use, you must discuss it with your supervisor.

Remember that this disorder can be treated, and recovery is possible.

**AFFECTIVE DISORDERS**

These disorders cause a change in mood. The two emotions altered are depression and mania.

**BIPOLAR DISORDER**

- There are three types of this disorder.

  a. Mixed

  Client has extreme mood swings of depression and mania. These moods are in themselves normal emotions, but the client with this disorder has exaggerated mood swings.

  Usually the manic phase is first, then behavior returns to normal. Client then will enter the depressed phase. Cycle can repeat itself.

  b. Manic

  Client has a manic phase, then behavior returns to normal.

  c. Depressed

  Client experiences depression, with a history of at least one manic episode.

Manic phase

- Behavior may be sexual.
- Speech is rapid.
- Thought processes are rapid, and the client seems to jump from one subject to another with no apparent connection.
- The client is very restless and cannot sit still (psychomotor hyperactivity).
- Client may have insomnia but not feel tired.
- Concentration is difficult.
- Mood is euphoric.
- Client eats little and loses weight.
- If crossed, client can be hostile and violent.

- Client may exhibit manipulative behavior.
- Client may have delusions of grandeur or may feel capable of doing anything.

**Care during Manic Phase**

Provide as nonstimulating an environment as possible.

Watch client's physical activity; hyperactivity can eventually lead to exhaustion.

Feed finger food at regular intervals.

**NOTE:** Client may be too hyperactive to sit down long enough to eat normal meals.

Show acceptance of the client as an individual; this does not mean you approve of the behavior.

Allow the client to express verbal hostility.

Channel client's physical activity if possible.

If the client is argumentative, do not argue back.

Depressive phase

**NOTE:** Between cycles the client is completely normal.

- Client's activity and speech gradually slow down.
- The client looks sad.
- The client may be withdrawn; young children, however, may be hyperactive.
- Client may have feelings of guilt.
- The client feels worthless, has low self-esteem.
- Client may sleep too much or too little.
- Client directs aggression inward.
- Client may become self-destructive and attempt suicide.
- The client will return to normal slowly.

**Care in the Depressive Phase**

Your client may be receiving therapy as treatment for depression. Group therapy with peers allows the client to identify with the group and know that others have similar problems. Play therapy for young children allows them to use toys to act out feelings they could not express to parents, siblings, etc.

If the cause is poor familial relationships, the whole family may need therapy. If the home environment has caused the problem, the child may need to be removed from the home. Severe cases may require drug therapy. A child who is self-destructive may need to be hospitalized.

Accept the client as an individual.

Set limits for behavior.

Discuss symptoms only when the client wishes.

Always be alert for suicidal tendencies, keeping in mind that there are no idle threats. If you think your client is considering suicide, tell your supervisor.

**NOTE:** Do not lightly dismiss a suicide threat from a young child. The number of suicide attempts in young children has greatly increased during the last decade.

## MAJOR DEPRESSIVE DISORDER

Depression is a normal emotion that we all experience at some time in our lives. A depressive disorder is far more serious than a case of the "blues." Depression can be fairly common in all ages, including children and infants.

### Characteristics

- Sad appearance
- Low self-esteem, feeling of worthlessness
- Guilt, even about things not under client's control
- Insomnia or too much sleep
- Weight gain or loss caused by eating more or less than usual
- Change in school or work performance

**NOTE:** A child may be truant or may refuse to attend school.

- Withdrawal from social situations, avoiding peers and normally enjoyable activities
- Suicidal thoughts, preoccupation with death

**AUTISM**

Autism is classified as a pervasive developmental disorder. Caring for an autistic client can be very challenging and frustrating. You need to know what characteristics to expect from this type of disorder. As with most disorders, however, one client will not have all the characteristics.

Characteristics

- Autism is seen in infancy.
- An autistic child does not interact with people and may be totally indifferent to them. The child does not react to cuddling or being held, and may fight against physical contact.
- Speech if present is not used for communication, and there may be echolalia.
- The client cannot differentiate fantasy from reality.
- The autistic client is fascinated by objects. The client may hold an object or look at it for hours. If the object is taken away, the client may react with violence or self-mutilation.
- Ritualistic behavior, such as masturbation, pacing, or twiddling fingers, is common.
- Autistic clients do not tolerate change, and everything in the environment must remain the same. Moving an object or preventing such clients from performing a ritual may trigger a violent reaction of rage towards others or themselves. This can include head banging, biting themselves or others, or total withdrawal.
- The client can have trouble eating or sleeping.
- An autistic client may have very poor verbal skills or may not speak at all. This does not mean that the client is retarded. Autistic persons are believed to be of above-average intelligence.

- This client responds to internal stimulation rather than external.

**Care of an Autistic Client**

There are no instant cures for this type of disorder, and therapy is usually life-long. An autistic client will never be outgoing, but may be rehabilitated to the point of functioning in society. This is not always the case.

Intensive psychotherapy is usually indicated and progress if any is very slow. Parents may also need therapy and much support. In some cases, removing an autistic child from the home may be in the family's best interest.

The respite care provider must follow safety principles at all times to prevent the client from self-injury or from harming others.

The respite care provider may have to set limits on behavior.

Nutrition may be difficult to maintain for the client.

You must presume that the client can understand you even though there is no response to what is being said.

Check with caregiver to learn client's patterns of behavior.

Avoid even minor changes in client's environment.

**POST-TRAUMATIC STRESS SYNDROME**

This anxiety disorder is caused by a very traumatic experience, one that is out of the ordinary, such as rape or physical violence.

Characteristics

- Reliving the traumatic experience
- Avoiding thoughts about the experience
- Numbing of emotions
- Irritability
- Depression or anxiety
- Insomnia

**OBJECTIVE 3**

Given case studies, describe appropriate behavior management techniques for emotionally disturbed clients.

**NOTE:** When you encounter disruptive behaviors, you must intervene to de-escalate potential problems. This can be a challenge, but very rewarding if successful.

**NEGATIVISTIC BEHAVIOR**

In this type of behavior, the client will resist what is considered right. The client has a very low self-esteem and may feel worthless or a failure.

Care

- If possible, eliminate the chance of negative choices.

  EXAMPLE: If the client refuses to eat, offer the client choices of eating with or without help from you.

- Try to make client aware of behavior that needs to be changed.
- Encourage the client to talk about his or her feelings about the behavior.
- Encourage even small steps toward improvement.
- Use reinforcers, such as favorite activities or food, for appropriate behaviors.

  **NOTE:** Clear any rewards with the caregivers.

- Keep the caregivers informed and get their support.
- Observe closely for any improvement.
- Always show consistency with the client.

**REGRESSIVE BEHAVIOR**

Regression is reverting to a previous level of behavior. Regression might be to avoid reality or to avoid meeting expectations. Clients may lose bladder and bowel control, suck their thumbs, refuse to drink from anything except a baby bottle, and even lie in a fetal position. Clients may throw tantrums or refuse to communicate.

Care

- Establish trust with the client by spending frequent short periods together, directing communication toward the client and calling the client by name. Use a quiet tone of voice, short sentences, and language the client can understand.
- Always keep promises.
- Try to help improve the client's self-esteem.
- Provide physical care as needed.
- Have a structured, controlled environment with as little change in the daily routine as possible.
- Let the client be as independent as possible. Encourage, but do not demand. Do not rush the client to perform activities, but assist as needed.
- Do not punish the client for failures.
- Encourage any improvement.

**AGGRESSIVE BEHAVIOR**

Aggression is destructive behavior often associated with anger and can rise out of frustration or overstimulation. The anger can be directed towards others, the environment, or themselves.

Care

- Maintain a quiet, calm, but firm approach.
- Avoid close body contact that may intimidate or threaten the client.
- Set limits for behavior, and give explanations for the rules and regulations.
- Request rather than demand

  **NOTE:** Chances of cooperation increase when clients feel they can make the decisions.
- Allow clients to express themselves.

  **NOTE:** If a client is verbally abusive, do not retaliate.
- Try to get the client aware of the problem.

- If a specific situation has caused the behavior, eliminate it if possible.
- Channel the aggression into an acceptable outlet such as games, sports, etc. if possible.
- Isolate the client if necessary.
- Use physical containment as a last resort.

**NOTE:** DOCUMENT ANY INCIDENT OF PHYSICAL CONTAINMENT:

Date, time of day incident occurred
Amount of time client was contained
Circumstances leading up to containment
Actions and strategies used to avoid containment
Actions (position and location) during containment
Results of containment, including injuries
Eventual resolution of incident

**MANIPULATIVE BEHAVIOR**

Clients may try to control or use others to meet their own needs. Often you can be manipulated without being aware of it. With this type of client, you must keep in close contact with the caregivers to prevent situations that pit you against them.

Care

- Note ways the client is trying to manipulate you.
- Tell client that you are aware client is using manipulative behavior.
- Do not respond to manipulative behavior such as flattery, obscene jokes, or vulgar language.
- Set acceptable limits and explain them to the client, but keep in mind that the client will test those limits.
- At all times be consistent, open, and honest.
- Never react with anger.

**SELF-DESTRUCTIVE BEHAVIOR**

Clients who engage in self-destructive behavior have a very low self-esteem and want to punish themselves. Self-destructive acts include continuous scratching even after bleeding begins, banging one's head against a wall, eating sharp objects, setting fire to oneself, and suicide.

Even relatively mild self-destructive acts are usually very distressing to an observer and may promote feelings of disgust. Your approach must be warm, gentle, and accepting.

Care

- Remain calm, but interrupt any self-abuse.

  **NOTE:** Do not ignore self-destructive behavior. The client's safety is your primary responsibility.

  EXAMPLES: Remove any sharp instruments, matches, belts, and cords. Keep cleaning supplies and medications locked up.

- Take care of the client's physical needs, and encourage client to get adequate rest and nutrition.
- Observe the client's behavior constantly and closely; do not leave the client alone for any period of time.
- If possible, assign simple tasks to channel the client's attention and energy.
- Try to improve client's self-esteem.
- Limit body contact except as a protective measure because clients may redirect anger and hostility toward you.
- Allow clients to express themselves.
- Be patient and honest with the client, but do not be critical of the client or show anger.

**HYPERACTIVE BEHAVIOR**

The client demonstrates exaggerated, excessive movements, and reacts impulsively and forcefully in an effort to control the environment. This client will not be able to concentrate on any one thing for any period of time. The hyperactive person is angry and fearful.

Care

- Be quiet, firm, and kind in your approach.
- Make the environment as nonstimulating as possible, with no noise, loud colors, bright lights, or exciting pictures on the walls.
- Discourage visitors; this client does not need contact with a lot of people.
- Maintain food intake by providing frequent small meals with finger foods, as the client will not slow down to sit and eat.
- Increase fluid intake to prevent dehydration.
- Take care of physical needs, including personal hygiene. If you bathe the client, observe the skin for any signs of bruises, injuries, or abnormalities.
- Allow clients to express themselves; do not argue.
- Avoid physical restraint; it will only make this client more agitated.
- Involve the client in activities that will span only a short period of time so that the client can achieve success.
- Set limits and explain them to the client.

**COMPULSIVE BEHAVIOR**

Clients perform stereotypical, repetitive acts such as washing hands—possibly up to 60 times per minute, washing hair, or masturbation. The clients are aware of doing these acts but do them to decrease anxiety; not doing them increases anxiety.

Care

- Do not interrupt the activity, but try to divert client attention to activities client enjoys.
- Develop a schedule that includes but reduces the frequency of the act.
- Spend time with the client to divert his or her attention from the repetitive act.
- Allow the client to verbalize his or her feelings. Try to focus communication on the problem.

**NOTE:** Interaction with a client will depend on the client's age and ability to understand.

- Encourage new behaviors and praise small improvements.
- Maintain close communication with the caregivers; and discuss all aspects of the client and concerns with your supervisor, reporting even minor changes.
- Keep in mind that the client will have poor judgment.

**SUPPLEMENT 1**

## General Care Guidelines

**PHYSICAL CARE**

The age and the condition of the client will determine the amount of physical care given by the worker. Find out from the caregiver any specific preferences that the client may have. For example, the client may eat from only certain utensils, or eat only a specific food or food that is prepared in a specific way.

If the client is being toilet trained, find out how the caregivers are training the client and follow that regime.

Some clients may object to being seen nude, or object to being bathed or touched by another person.

**SAFETY**

Upon entering a client's home, you should monitor it for potential safety hazards. Get into the habit of looking at a room for potential dangers. This is an important step in caring for all clients, but it is critical in caring for an emotionally disturbed client.

Evaluate each room in the house. Ask yourself questions about safety as you view a room.

EXAMPLES: Are any chemicals, medications, matches, or sharp objects within reach?
Is the room cluttered?
What type of heating does the room have?
Could a furnace or heater burn the client?
If there is a fireplace, is there a guard up?
Do the draperies have cords?

**FAMILY RELATIONSHIPS**

To be an effective respite care worker, you must develop a trusting relationship with the client and with the client's family. You will be entering their home, and you must accept their home life even if it differs from your own. You must adapt to the circumstances of the family unit, and you must follow the customs and habits of the family.

Discuss cultural differences that may affect the way you provide respite care. If you object to any of the family's practices, discuss it with your supervisor.

Never criticize the client, the caregiver, or the client's home.

## COMMUNICATION

Communication is a critical skill for those in respite care; you will have to communicate with the client, the parents and co-workers. In order to give good care to your client, you will have to develop a trusting relationship with those concerned.

Dictionaries define communication as a means to share, to impart, to transmit; or to give and receive information or messages in any way. Communication may be verbal or nonverbal. *Verbal* communication consists of reading, writing, listening, and speaking. *Nonverbal* (often called *body language*) is any way other than the use of words. Nonverbal includes facial expression, posture, tone of voice, appearance, or touch.

The process of communication includes three elements: the sender, the message, and the receiver. There are also therapeutic techniques, which enhance and encourage communication, and nontherapeutic techniques, which may block communication.

### THERAPEUTIC TECHNIQUES

These are techniques to encourage the clients or caregivers to express themselves.

- **Listening** — This requires concentration. You do not have to agree with what is being said, but the client needs verbal expression without feeling that you are passing judgment. Good listening is essential for communication.

- **Silence** — Your silence can either give the client an opportunity for expression or time to reflect on what has been said.

- **Comment** — Appropriate comments show interest and indicate you have been listening.

  EXAMPLE: "I did not realize you felt that way."

- **Reflection** — Repeating the client's statement prompts and encourages the client to focus on the topic.

  EXAMPLE: Client states, "I am worried about my grades." You might respond, "Your grades?"

- **Validation** — Comments can clarify your perception of the client's body language.

  EXAMPLE: If the client looks sad, you might state, "You look down; something must be troubling you."

- **Presenting reality**

  EXAMPLE: If the client sees someone in the room that is not there, you can state, "I see no one else here."

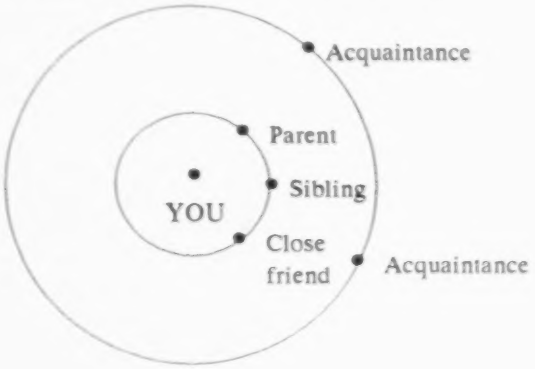
- **Letting client volunteer information** — Broad questions or statements encourage client to clarify information

  EXAMPLE: Client states, "They never liked me." You might respond by stating, "I wonder who they are."

- **Exploring** — Comments can draw out further information from the client.

  EXAMPLE: "Tell me more about that."

- **Maintaining physical distance** — Many people are uncomfortable with people close to them or right in their faces; never stand extremely close to the client.



**NONTHERAPEUTIC TECHNIQUES**

- **Reassuring**

  EXAMPLE: "Don't worry about that; everything will be fine."

- **Belittling or failing to listen**

  EXAMPLE: Client states, "I am going to die."
  You respond, "That's silly."

- **Defending — Repel an attack.**

  EXAMPLE: Client states, "You were not here yesterday."
  You respond, "I work very hard and deserve a day off."

- **Making stereotyped statements**

  EXAMPLE: "I know just how you feel."

- **Disagreeing**

  EXAMPLE: "That's wrong."

- **Interpreting** — State what you think the client means.

- **Changing the subject** — Avoid what the client wants to discuss if you are uncomfortable with the subject.

  EXAMPLE: "I don't want to talk about that."

- **Questioning** — Client may become uncomfortable and distrust you.

  **NOTE:** Not asking direct questions is generally best.

**DOCUMENTATION**

Always keep written documentation, even if your agency does not require it. You can refer to the documentation if there are any questions.

Document anything that is important. See examples on next page.

- If you or the client is injured, describe how the injury occurred, what the injury was, and what treatment—if any—was given.
- Describe the client's behavior.
- Note any change in the client, whether progress or setbacks.
- Describe the care you give to the client.
- Summarize anything of importance the client may express to you.

**SUPPLEMENT 2**

**From the View of the Child**

CHARLIE

My name is Charlie. I'm 4 years old and I go to a special school for E.D. kids. E.D. means emotionally disturbed. And to tell you the truth, I don't know exactly what that means but I can tell you how I got in this school.

My mom and dad work and at first I stayed with my grandma. Then she got sick and so I stayed with Lucy for a while. But she moved away. And I stayed with some other lady. I don't remember her name. And then I went to a day care center. I *think* all those other people probably didn't like me or they wouldn't have disappeared. After I'd been in the day care center a while, I was in trouble ALL the time.

I don't really know why. All I remember is everybody was mad at me all the time. Mom spanked me, dad yelled at me, and all the teachers ever said was NO, DON'T, and STOP.

And I kept hitting kids and throwing stuff even when I didn't mean to. I don't know why. It just seemed like there was something inside me that made me get in trouble. Sometimes I felt mad, sometimes I felt sad. Most of the time I was scared but I don't know what about. Sometimes I felt like everyone was trying to hold me down and stop me from doing what I wanted. Other times I felt like nobody paid any attention to me or cared WHAT I did. I thought everybody hated me. And I KNEW I hated me.

Then a lady came from the special school and talked to me and my parents. Dad said it was a last resort. And I was scared but it turned out to be OK.

My room is nice with great toys. There are lots of teachers and not too many kids. Most of them are real weird. One boy doesn't talk. He just sits in a corner and lines up little blocks for hours and hours.

Another girl talks ALL the time and is real bossy. One boy cries most of the time. And the rest of the kids seemed real mean at

first. But some of them are not so bad. Most of them are kind of like me...scared and mad and mixed up.

There's a doctor here that talks to the parents. He gives some of the kids medicine. Mom says I probably won't have to take medicine. But I don't believe everything everybody tells me.

Everybody says we're lucky to live in a big city where there is a special school for E.D. kids. Dad says that kids who live out in the country or little towns have E.D., too, but they don't have a special school. I guess we're lucky. I sure don't FEEL lucky, I wish I was like everybody else.

*****

**TRACEY**

My name is Tracey, I'm 7 years old. I go to Harrison Elementary School in a special class. I hate this class. I hate these kids. Everybody calls us retards. Most of the kids in my class are dumb or sick. As soon as I get bigger I'm going to run away.

I have a mom and a dad and two brothers and a sister. Well, I mean, they're not my REAL FAMILY, I'm adopted. Yeah, I know they're my real family but they're not my REAL family. Ever since I can remember my folks have told me I was chosen. I know what that means. And they mean well. But I'd like to get back with those people who un-chose me. Mom says that my other mom just couldn't take care of me. Well, that's okay, when I find her, I'll take care of HER.

Anyhow, I was going to tell you about this E.D. thing. That's what they call me and why I go to a therapist every week. I hate it.

But it's better than when I had to go stay in the hospital. My E.D. got so bad one time I had to go stay in the hospital for weeks and weeks. They stuck needles in me and took x-ray pictures of my head and gave me awful medicine that made me feel like a zombie. And I hated it!

The worst thing about being 7 and being E.D. is I don't really think anybody likes me. Everybody else has friends and everybody else looks like they're having fun. Mom says that's not true, that everybody has problems and troubles, but it sure doesn't look that way to me.

*****

**BRYAN**

My name is Bryan. I'm 11 years old. I live with my grandma and my little sister, Amy. My dad lives in an apartment building about a mile away and my mom lives in a house with her friend, David. Sometimes Amy and I get to go stay with Mom or Dad but most of the time we live with Grandma. I make my mom nervous and when I go with my dad, my mom always gets mad.

My mom and dad are divorced. I think they got divorced because of me. I have something wrong with me that means I have to go see doctors, and go to special classes. And special camps, and have a tutor, and a shrink, and lots of things that cost extra money. I think that if I could be good, Mom and Dad and Amy and I could all live together and be like families on TV.

I get frustrated real easy, and I have something wrong in my mind so that when I get upset, I just lose it. I mean I lose self-control, temper, everything! And it's like I can't stop myself and I can't think ahead or remember things from before.

I do okay in school most of the time. I mean, I'm smart enough, I guess, but I used up all my energy trying to stay out of trouble and didn't have any left to try and learn things. That still happens sometimes. Most of the time I just feel that if I could just disappear...fade into the woodwork...or float off into the sky...everyone would be a lot better off.

*****

**CHRIS**

My name is Chris. I'm 14. I am what they call autistic...that's a kind of psychiatric problem. Well, I'm not really autistic any more...I don't think I ever was, because the books I've read about autism say that if you have it, you don't ever get over it. And I have. Well, almost all the way. Plus I don't think that's what I had in the first place. I'm almost exactly like every other 14 year old. Except I get uneasy...anxious...about certain things.

For example, I like things to be where they're supposed to be. I like to stay home most of the time...or when I go...go to the same places, see the same people, eat the same things, read my same MAD magazines over and over, watch the same tapes, play the same computer games. It's just the way I am.

My mother says I've always liked rituals and routines. Maybe so. That doesn't mean there's anything wrong with me. It's just that if things are not where they are supposed to be or the way they are supposed to be, I just get frozen. I feel like my world is dissolving, and that maybe I'm going to die or something.

The other thing is that I don't like to meet new people. I don't want new friends like my mom keeps talking to me about. I'd be just fine if I never had to talk to anyone but my mom and my grandpa, and my dog Smokey.

My therapist says I didn't start talking until I was 6. I don't believe her. I remember lots of things from when I was 2 or 3, and I was probably talking then. I talk fine now. Well, not exactly like everybody else, but OK. Dumb, mean kids at school make fun of the way I talk. They say I sound like a robot or a mechanical man or something. They're crazy. I wish they'd leave me alone. The thing is, when they kid me, or I get uptight or something, I stutter. I mean, I try to talk, and the words just won't come. But sometimes words come just fine.

*****

**SALLY**

My name is Sally. I live in a foster home with my foster parents and some other kids. I'm 16 and this is the ninth foster home I've been in. My family got in trouble for abuse and or not having any money to take care of us, and all of us—me, my brothers and sisters—got split up and sent in different directions. One of the reasons I've been so many places is because I've run away a lot—mostly looking for my brothers and sisters. Once they put me in a big girls' orphanage and I didn't like that, so I'm trying to stay put till I'm 18.

They are nice to me here, and I'm in an E.D. class at school with an OK teacher and a nice counselor. They say I'm depressed. What have I got to not be depressed about? They gave me pills for it for a while, then decided they were making me an addict, which I probably am, so they quit. When I'm 18, I'll take whatever I want to.

Let me tell you something about E.D. kids. Mostly, we are super sensitive and smart. The world is a dangerous place. *Every*body *knows* that. But E.D. kids know it faster and better than most people. We have a sixth sense about dangerous places and people and things and we have to be very watchful and careful.

We know that you can't really trust a lot of people. And we try to protect ourselves. Sometimes that may look funny to other people.

Now, do you want to hear the absolutely most bizarre thing you've ever heard in your life? After all this crap I'm dealing with, all the problems I've got, on top of everything else, my counselor asked me if I would go to a state meeting at Shangri La where a bunch of people are going to be talking about emotional disturbances. And she wanted me to get up in front of all those people and talk about what it's like to be called E.D. Can you believe that? No way, ABSOLUTELY NO WAY!!!

Used with permission of the author, Fran Morris. Presented at Oklahoma Families as Allies Conference, October, 1987.

SUPPLEMENT 3

**Barb's Story: A Parent's Experience**

I have two daughters. Amy is nineteen, and Pam is seventeen. They were a year and a half apart in age, and Pam was born a month premature. When she was a year old, she was diagnosed as having hernias in her ovaries. She underwent major surgery when she was about thirteen months old. After the surgery, she went into pneumonia because she was not able to cough up after having the anesthetic; she ran a high temperature and was critical for several days. There were probably some developmental delays at that time with her, but I did not recognize them. I just felt that her sister was talking for her, doing things for her because of their closeness in age. She had to learn to walk again after the surgery. I did not really recognize any kind of learning problems or anything else at the time.

By the time she was four, she was not learning her colors or some of the things she probably should have been. I suppose I was in a stage of denial about it. At the end of kindergarten, the teachers were recognizing that she had some learning problems. In first grade, she was not learning to read. The teacher told me she thought she [Pam] was deaf. However, after all the tests at the Institute of Logopedics in Wichita, we found she was not deaf. We proceeded with more testing and learned she had a learning disability. When she was diagnosed, they did not use the words *learning disability*. They used the catchall phrase *minimal brain dysfunction*.

I did not understand and became hysterical when they placed her in special education. I went back to the doctor who had made the diagnosis for clarification of Pam's problem and was never given a satisfactory explanation. She was placed in special education about the second month of her second grade year. This was a major move for her because she moved out of the school she had been attending into one that had a learning disability program.

Finding out a child has a learning problem brings out a lot of denial in a family, including the grandparents. Pam's grandparents said things like "We don't understand this or know

what it is, but we just think you are setting this kid up by putting her in special education. That's for the mentally retarded." My former husband felt much the same while going through the denial stage.

Apart from that, we appeared to be just fine. I did not work outside the home. We were an upper-middle-income family. We had two nice cars, a lovely home, and membership in the Country Club. We were involved in a lot of social events, vacationing and socializing because of my husband's business. My husband drank more than he should; but I did not see it as a problem or as affecting our family, so I just put it into the background. Yet, as I look back, I am sure he was an alcoholic. To outsiders, our family looked very intact.

When Pam turned eleven, her body was swollen almost double its normal size, and she gained about twenty-five pounds. I rushed her to the hospital in a panic. The hospital called a kidney specialist. After having a kidney biopsy and several other tests, she was diagnosed as having Lipoid Nephrosis, which is a blood cell disease affecting the kidneys. It puts holes in the kidneys because protein is not being properly processed into the blood. Instead, protein is processed through the urine and kidneys. This causes edema and the body swelling. There is no cure for this disease. In the last few years, it has been learned that massive doses of steroids will put the disease into remission. It soon became evident the massive doses of steroids Pam was taking was having serious side effects, one of which was extremely high blood pressure.

Pam was put on a home-bound program at school because of her blood pressure. She had no peer interaction. I was with her all day, and it seemed all we had was each other. Other than being with Pam, I was spending a lot of time taking her to doctors and waiting on home-bound teachers to arrive at the house. Our food was selected and prepared around Pam's diet. Our lives evolved around this very sick little girl.

The family was under a great deal of stress, but I did not feel I had the right to acknowledge the stress. When Pam became suicidal, the stress was apparent. I felt the drugs had a lot to do with this; but regardless of the cause, my child was suicidal and this had to be dealt with. As a result of this, I was exposed to my first experience with the mental health profession.

We had never been to counseling. Just like any other family, we did not know where to look for help. I looked in the phone book thinking, "Whom in the world do I call to find help for this child?" I read, "Child Guidance Center" and thought, "This looks good; they treat children." That very day, I called them and said, "This is urgent! My child is suicidal and I'm scared! I am afraid if I leave her for one minute, she will commit suicide." They said, "Well, we will have someone call you back." I stayed home, did not make any phone calls, and worried. After two days of waiting and watching this child day and night with no rest, I called them back only to have them tell me they would probably take her but they would have to have a staff meeting to see which psychologist would see her. They said, "We will have a social worker call you after we have discussed her case and made a decision." I felt that this was an emergency!

The social worker called me that same day and said it would be about four weeks before they could get her in. I said, "Four weeks!" Not knowing better at the time, I just accepted it and went crazy the next four weeks waiting on *them*. Not having had experience with the mental health profession, I did not know they did not have the right to tell me to wait four weeks. I was not thinking there were other people in that phone directory. I thought this is how they all ran their business.

After four very intense weeks, we got in. The counselor they had selected for us was a woman who dealt with a lot of adolescent abnormal behaviors. Her name was Ruby. Ruby was single and had never had children. However, supposedly, she had done a lot of work with adolescents. She immediately informed me this counseling was not going to work and she would not consider seeing us again unless the entire family came in. Our entire family did not want to go. Amy, the older child, did not want to take time off from school and my husband did not want to take time off from work. However, if we were going to get counseling and help Pam, we were all forced to go.

Our first visit consisted of a round-table type discussion. After that first visit, however, the time was spent by my going in first and telling Ruby about what was going on in our family. Pam would then get to visit with her. We shared the hour. Pam tells me today that she felt resentful because I went in first and sometimes took far too long. There were times when Pam would only get fifteen minutes with Ruby. Pam also felt guilty because Amy would have to be taken from school to attend sessions with

Ruby. We would pick Amy up at school and she would complain all the way to the counselor's office about not wanting to go. This caused problems in the sessions.

At one point during the time of our counseling with Ruby, I was admitted to the hospital for a hysterectomy and was unable to go to counseling. The counselor called me in the hospital and told me to have my husband bring Pam in for counseling. They had to be kidding! He was in a real denial stage and felt nothing was wrong with our family to begin with. Now they are telling me to have him bring her in. He did not want to take Pam, much less pick Amy up at school to go. He also did not feel he had the time. Things became even more stressful, and our marriage was under a great deal of strain.

I continued to live each day, collecting urine specimens and keeping them in the refrigerator, running to the dialysis center, and running Pam to counseling a couple times a week. I was getting no cooperation from my husband or Amy. Finally the counselor said she would refuse to see us again unless the whole family came. It all seemed a vicious cycle, and we were getting nowhere.

A couple of months into this counseling, I realized Pam was locking herself in the bathroom and doing about five hundred sit-ups a day as well as riding the exercise bike about two miles each day after eating. This bizarre behavior was really making me scared. I was hearing more and more about anorexia nervosa. I called Ruby. Ruby said, "Oh, I've been meaning to tell you that I think Pam is anoretic." I had just been released from the hospital and was unable to drive myself to Ruby's office. I had to call my husband at work and have him come home to take me. I was so upset. I asked Ruby why she had not told me of her suspicions before now! She said, "I've seen the symptoms and I am going to be real honest with you: my niece died of anorexia. I just do not think I can deal with it." I asked her what she would do if Pam were her child; and she said, "I would institutionalize her. You do not have the capability to care for her at home."

My husband drove me from Ruby's office to the dialysis center. I grabbed the doctor and said, "You've got to help me; my daughter is anoretic". He told me she was not anoretic. I told him she was losing a lot of weight; and he just said, "She has gained a lot of weight, and she is just real conscientious about

her weight. It's all right for her to lose some weight." I also told him Ruby thinks she should be institutionalized. He told me there was not a private hospital or institution in this state that would be able to take care of the kidney disease. He said, "You can't institutionalize her."

Ruby bowed out of the program, which was the best thing that ever happened to us. I called the Mental Health Association because I knew this child needed some intensive help and needed it fast. They gave me the name of another parent who has an anoretic child. I called her to see what she was doing about it. She told me she had not acted fast enough or wisely enough and that her child was dying with anorexia. She did give me the name of what she termed "a good psychologist" located at the KU Medical Center in Wichita. So I called him. He advised me they were putting a new children's psychiatric ward in St. Joseph Hospital and that he would not be in a position to work with her for about a month. By this time I was in another real panic.

Pam was down to seventy-six pounds (she was about 5'6" at the time). I could not believe this doctor was telling me I had to wait another whole month to get help. I asked him what I should do in the meantime. I said, "You tell me what to do. Do I remove everything from around her, like the exercise bike? Do I watch over her and not allow her to do the sit-ups? You tell me what I need to do. She is eating on small plates, eating small helpings, feeding her food to the dog, and taking food to the toilet and flushing it. She is starving!" He told me I could remove the exercise bike if I wanted to but there is virtually nothing I could do.

I immediately called my husband and asked him to come help me through this crisis. He picked me up and advised me he had five minutes. I told him what the doctor had said and that Ruby thought she should be institutionalized. I asked him to help me decide what **we** should do. He said, "I would just like for you to tell me what the hell you think I am supposed to do? I am not qualified to make that kind of decision." By this time my husband was coming home drunk every night so he would not have to face it. This was his way of escaping. Amy could not have any friends over because she did not want them to see her dad drunk. He was also becoming physically abusive to me.

I felt real stuck! I have a husband who is beating me, no therapy because nobody wants to help us, and we are not getting into the KU Medical Center because they are working on the psychiatric unit. I finally called the head of the KU Medical Center psychiatric unit. I told her I have got to get some help and I have got to get it now. I said, "I don't care if you are putting in a new psychiatric unit; either you help me now or tell me of somebody who can help me. I am desperate; our family is falling apart." She scheduled an appointment for a week later.

Two days before the appointment, I was hospitalized for blood clots in both my lungs. Pam was also in the worst relapse she had ever had with her kidney disease. Here I am with a drunk husband, an anoretic kid, an older daughter who had not had the benefit of a mother in I don't know how long, and I am stuck in the hospital! I told the lung specialist all of this and that I was going to walk out right now. I did not care where my blood clots were. I did not have anyone to take care of Pam unless he wanted to hospitalize her in the bed next to me. I could not trust my husband to cook low-sodium-diet meals. At this point, I am about as crazy as a loon! The lung specialist said, "You won't be helping your daughter by leaving here because you will die. You have moving blood clots in both lungs and both legs. You are going to be in intensive care. I have called an ambulance to pick you up." I told him he would have to put me in a psychiatric ward because I was going to have a nervous breakdown right there.

However, I did go into the hospital and was there about two weeks. Pam did survive my absence. The kidney specialist, (who lived right down the street from us) dropped in and checked on her regularly. Every day he drove to our home and checked on her. This was part of the bargain I had made upon going into the hospital. After being released from the hospital, I went home to face the problems.

We had rescheduled our appointment with KU Medical Center. Going to KU Medical Center cost us one hundred dollars an hour, and we went three times a week for different sessions. My husband and I saw a different psychologist and had a psychiatrist watching over us as a group. We had twelve people watching over us in all. We became guinea pigs for students to learn from.

We had four psychiatrists that led teams who watched behind a glass window in every therapy session. They observed how we walked in, where we sat, and how we sat. The dynamics of the family was what they were studying. We got nowhere. The were only interested in the dynamics and the cause. We were tested, retested, and tested again. Every time we saw someone new, they wanted to retest us. Nobody believed anybody else's records. Pam was humiliated during these sessions. They would strip her down stark naked every time we came in. They would weigh her this way. Then they would threaten her with "Lose two more pounds, and we are going to hospitalize you." This was not the kind of therapy she needed. She needed some type of behavior program. Instead we were getting the psychoanalytic approach to our "crazy family." None of us wanted to be there.

We felt we were just a test case for the whole educational system at KU. We were not being helped. Keep in mind, we were spending approximately two thousand dollars a month for all of this. We were dealing with all the psychiatrists, students, and the kidney specialist as well as the school Pam attended. They were having problems with her physical and medical needs.

It seems when things begin to happen, they happen all at once. My father died three weeks after our treatment at KU. I filed for a divorce shortly after. I decided if I was going to grieve, I might as well get it over with all at once. It was the best thing I could have done for myself. For about six months, the grief was almost overwhelming. My husband made things real difficult for us. I am sure these tragedies developed a lot of character and survival strategies within all of us. We know we can survive anything now. We know that probably nothing can get us down.

With the understanding of anorexia nervosa at the time, a lot of blame was put on us. They said, "It's these kind of parents who have anoretic children." They were talking of higher income families. They said it was usually the second daughter. It happens when the father does not play a strong role in the family. The mother is usually the dominant figure. We had all of that. However I know families who are like us and do not have anoretic kids. Therefore, I did not feel comfortable being labeled in this manner. I felt guilty thinking we had caused all of this.

Pam began to eat. She was not well, but she did begin to eat. I do not know why. I cannot give anyone who had attempted to help us credit. The kidney disease was in and out of remission for many years. Pam finally went on chemotherapy. She was on massive amounts of chemotherapy, and she did well with it. A lot of the decision was hers as to whether or not she wanted to handle being on this drug. She was fourteen years old, and we felt that she had some say in the fact that she was probably going to be sterile and she may lose her hair. That is a lot of mental strain for a fourteen-year-old, a lot of "big" decisions to make. As I look back, no wonder she was "crazy." She was put under a lot of stress and strain having to make adult decisions concerning her medical treatment.

We finally did get a therapist in Wichita. He was very similar to her present therapist in attitude, strategies, and the behavior plans he made for her. Neither therapist blamed me as a parent. I did not even go to the sessions. It was the biggest relief I had ever had. He did not say that I was crazy and I needed to be there. He said, "She has some problems, and I think we can deal with them. She still has some problems with some of the anoretic tendencies. They are her problems, and she needs to take responsibility for them. They are not yours." It was the first time I had ever heard anyone say anything like that. I let her go. I took her, dropped her off, and left. It was wonderful!

However, about once every couple of months, I would meet with the therapist, but never about Pam. He never said one thing about her. It was normally about me. He just wanted to make sure I was doing OK. I did not know what he and Pam talked about. Pam goes to therapy, and they do their thing. I did not want to know and I did not care. I want her to be healthy, and I want her well.

There was a bonding between her and me that was pretty unhealthy. Now that she is trying the transition into a life of her own, we are having a lot of difficulty breaking that bond that was created because of the problems we experienced together. The protective role I played for a lot of years with her is now beginning to be an issue. I was having trouble letting go, and she is having trouble letting go. Some of the family dynamics from the past were showing up. Her dad had never played much of a role in her life since our divorce. Her older sister is in college, and we are going through some real struggles. I still go through a lot of denial about it and do not want to think we are

still struggling. I would rather think things are okay. I put off dealing with things until I have to deal with them.

If someone were to have come into my "crazy" home while we were dealing with all of this, they would have had some real questions about me. After my dad died, I found myself lying at the bottom of my closet. My husband was mowing the yard, and I was just lying at the bottom of my closet. I was literally as insane as I have ever been. I think we had some type of a therapy session that day with KU that was not very positive. KU would leave us hanging. They would allow us to go home with Pam running down the hall, hysterical, and they would be shouting a plan of action for us for the next week as we were leaving. "Now, don't forget, what you need to be doing is...." She was already out to the car. She would be sitting in the car talking. She was pretty hysterical because they would allow her to scream and yell at me about the kind of mother I am and what kind of things I had been doing that had caused her reaction to herself. I would cry, and she would get angry. There was never any finality to it.

I was dealing with the frustration of my dad's sudden death (we had always had a real close relationship). He was the only one who ever provided me with respite so I could leave the house. He would care for her while I was away. I was thinking, "What a time for him to die." I was also thinking, "Now do I have permission to divorce since I don't have to live up to my father's expectations?" All of these things were running through my mind as I was lying in the bottom of the closet. I was thinking about the changes that would have to be made if I were going to survive all of this. What had been a normal family was just bits and pieces.

Three years after my divorce, we moved to Lawrence and I began work on a grant project. Going back to work after our divorce was one of the best things that happened to me. I did learn I could take care of Pam. I could be a mother and work as well. I could do things I had never thought I could do by myself.

My older daughter had been taking a real back seat during all of this. She had been wounded also. One day I found her in a fetal position in the bathroom. She said, "You've got to tell me what's going on here. Is Pam going to die? You and Dad are having such problems. What's wrong?" I had never bothered to share with her what was really going on. She was going to

counseling sessions (which she hated) and getting nothing out of them. She saw them as a big waste of time.

We did not know we had options. We did not have to stay there and go through this. We did not know there were other people out there that might be able to help us in a more positive way. Once we got on the right track, we were okay. It was about three years of worthless, expensive, financial stress. My husband had his own business and a good one at that. It enabled us to pay for all of that. But we were out of pocket about six hundred dollars for medical expenses and about two thousand dollars a month for psychiatric expenses. I do not know very many families who can tolerate that kind of financial drain. It adds to the stress.

We worked through all this over a period of seven years—the bitterness and guilt Pam had in feeling responsible for destroying her family. It had appeared, to her, to be quite intact. Obviously, there were things that were not intact before her problems started. Pam's problems only brought it all to the surface.

Providers need to know that when they walk into a family's home and they appear to be real "dysfunctional" and real immobilized, what they are saying is, "I need somebody to provide some case management, someone to take over coordinating all the services. I know I needed somebody to tell me that. When a provider walks into a home to provide services, the family is not just dealing with a "crazy" kid. They are also dealing with a lot of other family dynamics. Maybe a sick marriage, maybe an alcoholic family member, or no support in the household from each other. I have heard families say, "We haven't communicated and talked in five years. It's all we can do to get up in the morning, get dressed, and get out there to work." They still have to come home and deal with the same problems. They cannot mobilize beyond that because there is no way to do it.

As I look at families now, I know they need support in thinking they are not all crazy. The families that respite care workers will be dealing with are going through those very stresses. They will survive. They need somebody else who has come through to say it. It does not help when just anybody says, "You'll make it."

My extended family was no support at all to us. Maybe for others they are, but not very often do I see families who have

had good support from extended families. They are feeling the same things we as the parents feel. That child is a part of them too, and they do not want to believe anything bad may be happening. Many times they blame the parents also. They do not want to think they may have contributed. So they back off from the problem and stay in a stage of denial.

Parents of the mentally retarded and physically disabled have had systems of support for many years. They have seen the need to be organized and have done so. They know how to mobilize. Parents, for example, who have a baby born with Down's Syndrome have an immediate support system. They are offered immediate support. Parents of children who are emotionally disturbed have never had any kind of support. None of us have ever had anybody who said, "It's okay." We have only had psychologists who have blamed us.

We have had terrible experiences working through the system, very few positive experiences. No one has been there to say, "It's okay; these experiences are not your fault." We have never known where the other parents are who have children who are emotionally disturbed. We knew some of them at school, but we never had a way of reaching them. Up until recently, we have had no way of giving them the information they need. Therefore, they have gone without family support and resources. Parents of children with emotional disabilities are years behind parents who have children with other disabilities. Parents like myself have gone through all the frustrations and never had any of that support.

I joined the Association for Children with Learning Disabilities because the first thing a parent needs with any child is information. I had an immediate system of information. It cost ten dollars to have them mail me information concerning this type of disability and the information concerning support resources. I still receive information from them.

Used with permission of Barbara Huff. From "Barb's Story: A Parent's Experience" as seen in *Rest A Bit* by Richard Donner; Topeka, KS: Rest A Bit of Families Together, Inc.; 1988.

**NOTE:** This story could happen anywhere; the problems encountered are not unique to any one state or agency.

SUPPLEMENT 4

## Recognizing Cultural Differences

Just as no two families are alike, no two subsystems of a cultural group are alike. Understanding of the influences of cultural differences caused by cultural background is made difficult because of this diversity in every ethnic group. At the risk of overgeneralization, the following is an attempt to provide you with accurate information on general family and child-rearing characteristics for each of the major minority cultural groups that child-welfare workers currently encounter.

### THE BLACK AMERICAN FAMILY

Many relatively recent studies of the black family have depicted the black family as pathological, disorganized, victimized and amoral. This popular view, however, contradicts the experience of most black Americans. The standard picture is that of the unwed mother, illegitimacy, the pathological matriarch and the emasculated male. Social reformers and scientific studies have done more to develop and reinforce this misconception than to support the unique characteristics of the black family.

Many studies have failed to conceive and analyze the black experience within the context of the black community and to focus on the strengths of the black family. Studies have tended to focus on the disadvantaged minority of the population and not on the scores of stable households or the ninety percent of all black families who are self-supporting.

The black family reared in white society shares many of the society's dominant values—work ethic, goal orientation and achievement orientation. Further analysis of the black community's values reveals that blacks, although removed and isolated from their cultures, have been able to shape values from traditional African philosophical attitudes about self.

### COMMON BLACK AMERICAN VALUES

- **Spontaneity**. There should be no restraints in dealing with people and life.
- **Naturalness**. "Being for real" is expressed in a free and sometimes impulsive approach to life.

- **Authenticity**. Cut away the "jive," "bull," and phoniness.

- **Humor**. Humor has been a valuable survival, as well as entertainment, tool for the black community. The ability to make light of a situation to ease tension, or to appear to poke fun at oneself was a frequently used defense mechanism to shield the black family from real or perceived hostile forces.

- **Family love**. Family before self.

The black family has played a significant role in screening and protecting its members from the dehumanizing features of American society. However, the extended family has been most instrumental in ensuring the stability and well-being of the family. The role of the extended family has been to provide services that would ensure the survival of the family. Relatives, friends, and members of the community often assist with child-care responsibilities, contribute to the financial security of the family, care for the elderly, absorb children without parents, and provide emotional support to members of the family.

In financially secure families, family roles are very traditional. The father is the head of the household, primary decision-maker, and provider. The mother is expected to assume the child-rearing and household responsibilities. In families that cannot rely on the earnings of one member, roles are more flexible. Role flexibility has been one of the most important survival tools of the black family. The ability of family members to assume different roles enables the family to cope with varied and unpredictable economic situations. The mother is prepared to be the primary provider or head of household if circumstances force her to. If the parents are absent for any period of time, older children may be expected to assume parental responsibilities by taking care of younger siblings. Likewise fathers are expected to take care of the home if the mother is away. Family roles are also exchangeable among members of the extended family.

Economic and social conditions frequently made it necessary for black women to contribute to the income of the household, even in two-parent homes. Although black women have historically contributed to the financial well-being of the family, their ability to easily assume head-of-household responsibilities has unjustifiably earned them the stigma of strong matriarchs. This matriarchal image is strengthened by society's refusal to

recognize black males as authority figures. However, even in households where the woman may be the primary provider, studies have indicated that equalitarian patterns of shared decision-making and household responsibilities often exist.

In addition to the extended family, the church has traditionally been one of the strongest social institutions in the black community. Religion has been used as both a mechanism for survival and advancement. Most of the community's cultural, social, and political activities have centered around the church. Self-help services have frequently been provided through the church. When you are doing an assessment of a black family, keeping these family characteristics in mind can help. You identify resources available to the family that you might not have identified otherwise.

**STRENGTHS OF BLACK FAMILIES**

- Extended family — strong kinship bonds
- Adaptability of family roles
- Strong religious orientation
- Self-help community organization such as churches and fraternal/social organizations

**CHILD-REARING PRACTICES**

- Families tend to be child-oriented. The focus is around the welfare and development of children.
- The family plays an important role in protecting children from "hostile society" by emphasizing learning survival techniques and pragmatic skills.
- Child-rearing responsibilities are usually the female's; however, male members of family may assume child care duties if circumstances necessitate it.
- Older children help in the care of younger ones and may also serve as role models.
- When children are mentally and physically able, they are expected to assume household responsibilities.

- Boys are generally taught manliness and masculine-related tasks while girls are taught household tasks and feminine responsibilities; however, flexibility in role reversal is also emphasized by parents for survival.

- Children are taught to be strong and independent, and that they must be better than whites to succeed.

- Physical punishment is accepted. "Spankings" or "whippings" are widely used forms of punishment.

**THE NATIVE AMERICAN FAMILY**

Native Americans today remain the most culturally diverse of the ethnic groups in the United States. Family life, cultural and religious practices, value systems, language, and dress vary greatly between Indian groups that have lived on the same continent for centuries.The Bureau of Indian Affairs recognizes 493 Native American groups in the United States. This large number of autonomous groups attest to Native American diversity. Each group has its own distinct linguistic traits, religious practices, and social organization based on the needs and values of the group. The Native American's strong tradition of allegiance to the group first has played an important role in preserving the unique qualities of each group. Even today, most Native Americans continue to identify themselves by their group's name (Blackfoot, Sioux, Navajo, etc.). Although increasing numbers of Native Americans are born outside the reservation setting, many continue to register their families with their ancestral tribe or clan.

The value systems of Native American groups are as diverse as other aspects of their life-style. However, there are some values that are shared by most groups. How these values are expressed or interpreted by the group may be affected by social and political customs, and religious beliefs.

**VALUES SHARED BY NATIVE AMERICANS**

- **Self-reliance**. Native Americans generally prefer to be self-reliant and may be hesitant to ask for or receive help. This is often interpreted by a social worker as belligerence and stubbornness. It also confirms the tendency of the American Indian not to seek help until the absolute last minute of an emergency.

- **Non-interference**. Most Native American groups consider interference in other's lives as a sign of disrespect. They generally practice the "live and let live" philosophy, allowing others to make their own mistakes and decisions. They expect the same to be afforded them. Thus when a social worker intervenes in family life, it is interpreted by many Indians as an act of disrespect, a threat, and an insult. However, support and assistance from a perceived member of the extended family is not considered interference.

- **Non-confrontation**. Many Native Americans prefer not to confront people when they disagree with them. Instead, they will avoid them. If a social worker tells Indian parents that they must take their children to school, the parents may appear agreeable and compliant, but once the social worker is gone, simply refuse to comply. Often this is interpreted as belligerent, stubborn, noncooperative, and immature behavior. It is important to understand this dynamic in interpersonal relations.

- **Diversity**. This is a principle that Native Americans understand and respect. It is important that non-Indian social workers understand it also, so that they do not generalize about Native Americans inappropriately, or lump them all into some large category or definition.

- **Respect for elders**. Native Americans traditionally revere elders in their society. It is believed that elders have a broader perspective of life because they have had a longer experience with it and more time to adhere to the philosophical constructs of their society. Thus it would be difficult for a young social worker to be accepted if he or she should patronize an older Indian client.

- **Extended family**. The kinship bonds in most American Indian groups extend beyond the blood relatives on both sides, to nonrelated friends and members of the tribe or clan.

Since each Indian tribe represents its own unique social system, it is inappropriate to discuss Indian family practices in general terms. Further, the Indian family in most societies does not exist as a self-contained entity, but within the context of the tribal community and clan. The structure of Indian society is based on its origin, and the origin of tribal society is based on a philosophy of interdependence. This requires the development of

well-defined kinship patterns. Regardless of the descendent patterns of the societies (some are matriarchal, patriarchal, and a few are anarchial), most societies have developed complex ideologies of relationships within the tribal society and between its members and nature.

Because of the community aspect of Native American life-styles, the extended family concept is very important. The kinship network is seen most effectively at work in the child-rearing practices of most groups. Parents, especially new parents, are not expected to assume complete responsibility for raising their children. All adult members of the family and community serve in parental roles. Although in many Native American cultures it is the female's responsibility to raise children, male members of the family become actively involved in the rearing of male children early on. Thus it is not unusual or considered abandonment for a child to be left in the care of grandparents or other relatives for an extended period of time.

Awareness of Native American family characteristics should help you identify additional resources within the Native American community to assist in carrying out essential family functions.

**STRENGTHS OF THE NATIVE AMERICAN FAMILY**

- **Extended family network/interdependence**. Encourage children to be left in the care of a relative or friend when the parent must leave the home. The social worker should interact with other members of the family, as well as the parents, who are actively involved in the child's welfare. For Native Americans living in urban areas, the social worker should identify Indian-related services in the community whenever possible.

- **Strong group affiliation**. This concept is especially important for urban Indians who are more removed from the extended family network that exists on the reservation. For families that don't have relatives who live near them, assist them in establishing contact with Indian groups or families of their tribe that may live in their community.

- **Cultural respect**. Social workers should respect cultural practices that are observed in homes of families they visit, even though they may not understand the practices or they are counter to what is practiced in their own homes (i.e., an

elderly Indian may offer the best chair in the home to a guest even if it is the only chair).

**GENERAL CHILD-REARING PRACTICES AND BELIEFS**

- Children are central to community; they represent renewal of life.
- Tribal philosophies, beliefs, and values vary and influence child-rearing practices to conform with tribal norms.
- Child-rearing responsibilities are shared by numerous caretakers.
- Children are allowed to develop freely, make own decisions and mistakes; little concern for task assigning.
- Children are respected and given more equal status than in dominant society.
- Grandparents have special role of passing on cultural values and beliefs to help develop tribal identity.
- Education and training is usually not structured but gained through experience, observing, and copying behavior of older siblings and role models.

## THE HISPANIC/ LATIN AMERICAN FAMILY

People of Mexican and Hispanic origin have been a part of U.S. history since the pre-Colonial days. Evidence of Spanish and Mexican cultural influences have been woven into the fabric of American life. This is especially true in the southwest where one can find cities and landmarks with Spanish names, as well as Spanish cuisine, language, and architectural styles. The Treaty of Guadalupe Hidalgo (1848) granted U.S. citizenship to the Spaniards and Mexicans who had settled and remained in the areas now known as Texas, Colorado, Arizona, and California after the Mexican-American War. Mexican-Americans today are the largest group of Hispanic/Latino peoples in the U.S., comprising over 59.4 percent (March, 1979) of the Hispanic community. Other groups in the U.S. in order by size of population are Puerto Ricans, Cubans, Colombians, Dominicans, Ecuadorians, and Argentineans.

**GUIDING PRINCIPLES AND VALUES**

- **Extended family**. The informal network that ties distant relatives, non-blood-related friends, and neighbors to members of the family.

- **Compadrazgo**. The vital link in the extended family that commits members of the family to help each other and ensures that the younger members of the family will be cared for.

- **Dignidad**. High value on honor, dignity, and pride which Hispanics traditionally place on the individual.

- **Mutualism**. Shared responsibility among members of a group, especially members of the extended family.

- **La raza**. "The race"; a concept that is evident today in many Mexican-American communities as they maintain ethnic pride and identity by asserting their identity as Chicanos (a folk derivation of "Mexicano").

Notwithstanding differences in nationalities, traditional family values are very consistent throughout Hispanic/Latin cultures. As is true with other ethnic groups, the extended family concept is the foundation of the family. The concept of compadrazgo is expressed in the Hispanic family by selecting godfathers and godmothers for children at birth to ensure that children will be cared for in the event that the parents die or can no longer provide for the care of their children. This internal adoption system absorbs children of the family and delineates the responsibility for their care; however, it does not preclude other members from contributing to the support and care of children and from serving as role models.

Most Hispanic/Latin families are traditionally strong patriarchies. The father is the authoritarian figure, assuming most of the decision-making, income-earning, and disciplinarian responsibilities. The mothers's responsibilities are generally limited to child-rearing and housekeeping tasks. However, studies indicate that some financial decisions may be shared by both the husband and wife, especially where it concerns the purchase of an expensive item.

Elders are revered, unquestioned authority figures whose roles are to act as teachers and pass on their knowledge to the young members of the family.

Children are taught to be submissive and obedient to the will and dictates of the father and other male members of the family. The eldest children are expected to begin to assume child care

and household responsibilities by their preteens. Use the strengths of Hispanic/Latino American families to identify resources within the community to help provide protection and permanence to vulnerable children.

**STRENGTHS OF HISPANIC/ LATIN AMERICAN FAMILIES**

- Extended family, especially if compadres and comadres are located in U.S.
- Religious ties — Catholicism is very strong in most Hispanic and Latin communities. Many groups have worked effectively within these communities when they have involved the church in their activities.

**CHILD-REARING PRACTICES**

- Women are the primary child carers.
- Fathers usually dispense physical punishment, and mothers frequently act as peacemakers and protectors from father's punishment.
- Sex roles are rigid: fathers are authority figures; mothers are child carers; girls are given less freedom and are more carefully observed than boys.
- Child-care responsibilities are shared by others in extended family when parents are unable to provide for their children.
- Children without parents are absorbed through informal adoption systems.
- Children are taught obedience and respect for older members of family.
- Good manners, respect for parents and relatives, and appropriate sexual behavior are rewarded and reinforced.
- "Verbalization" may precede, replace, or accompany punishment.
- Parents feel they have a legal and moral right to physically punish children.
- Certain areas of the body are generally avoided when dispensing physical punishment (to hit in the face is considered humiliating and abusive punishment).

## THE ASIAN/PACIFIC AMERICAN FAMILY

The Asian/Pacific American experience in the U.S. has been typically romanticized as the classic American success story—disadvantaged people migrate to the U.S. and through hard work and diligence, achieve "The American Dream." The labeling of Asians as "model minorities" ignores their long history of racial discrimination and implies that their success was achieved by overcoming few social obstacles. In reality the Asian success story is misleading, particularly when compared to European immigrants.

Although today many Asians are not as disadvantaged as other ethnic minorities, they are included in our discussion of ethnic groups for two reasons:

1. Their status as the "model minority" implies that they no longer experience discrimination and that members of their ethnic group do not need the types of social services that are generally directed at minorities. Both assumptions are false from the Asian perspective.

2. The recent Indochinese refugees have been identified as the new disadvantaged group and are eligible for a variety of social services as a result of their refugee status.

Currently the Asian/Pacific groups represented in significant numbers in the U.S. are Chinese, Japanese, Filipino, Koreans, Vietnamese, Indonesians, Malaysians, and Pakistanis. Each of these groups is made up of several ethnic groups itself. Again, there is wide diversity among groups identified as Asian Americans.

## COMMON ASIAN AMERICAN VALUES

- **Harmony**. The belief in harmony of Asian culture is rooted in Confucianism. Maintaining harmony and good relations in the home and with others is very important. To prevent offending or hurting someone's feelings, Asians will frequently avoid direct confrontation, saying "no," and expressing anger or displeasure. Often their behavior is misinterpreted as stubbornness or "beating around the bush."

- **Losing face**. To many Asians, especially an Indochinese or Southeastern Asian, losing face, embarrassing oneself or shaming the family, is unbearable. The stigma of losing face is frequently used by the family and Asian societies to control deviant behavior.

- **Respect for elders.** Elders are highly regarded in Asian cultures. Elders are not questioned but obeyed and are considered right or appropriate in their judgment and behavior.

- **Proper form**. Tradition, decorum, and proper form is very important and is often strictly followed in social practices and customs. How guests are received and meals are prepared and served may take a precise ritualistic form.

- **Family loyalty**. Primary loyalty is to the family.

The head is considered the sacred part of the body. It is offensive to touch Asians on the head or shoulder unless both shoulders are touched. Especially to Cambodians, putting your arms around their shoulders can only be done by close friends or relatives.

In Asian cultures the family lineage is usually paternal with wives joining the families of their husbands. Elders and males are highly regarded in traditional Asian society. All members of the household, even married sons, are expected to obey the father as head of the household. Although in many traditional Asian societies, women are resigned to being submissive and passive, they maintain a strong but subtle influence in family leadership. Young girls are taught to take over the financial affairs and to run the family from an early age. The husband and father is usually not expected to do anything with the family finances except earn the money. Sons are rarely expected to do household chores. Only after a woman becomes an elder in her family can she assert any authority, and even then her authority is generally restricted to female members of the family.

In financially secure families, women are responsible for caring for infants, instructing young girls, [doing] household chores, caring for elderly, and [managing] household finances. However, in many rural families, women are expected to contribute to the work force as well as handle all household responsibilities; therefore, the concept of the working mother is familiar to the Asian family.

The extended family concept usually extends beyond the family to the community, nation, and race. Today, mutualism is still very much a part of Asian culture in the U.S. as the actions of a

member of the family or race can bring shame upon the entire family or embarrass their people.

The following list should help you remember strengths of Asian American families and identify resources available to such families.

**STRENGTHS OF ASIAN/PACIFIC AMERICAN FAMILIES**

- Community ethnic associations
- Reestablishment groups, such as the Mutual Assistance Associations, that are culturally sensitive groups developed within the Indochinese community to aid in resettlement and orientation of refugees
- Family loyalty and unity
- Extended family and mutualism
- Devotion to children

**CHILD-REARING PRACTICES**

- Children are viewed as gifts from God.
- In ancient China, parents often dressed boys like girls and put silver dog collars on them in the belief that this would protect the child from evil spirits. Today, the custom is still practiced by giving children pet's names for nicknames.
- From infancy through early childhood, children maintain close bonds with mothers and are generally indulged.
- Children's needs are readily met.
- Children are generally reared by female members.

Up to 4 to 5 years of age, children's behavior is accepted usually without formal disciplining. Parents tend not to discipline or place extensive limits on their children.

Role modeling impresses on the child the importance of elders and how they are to be respected without question. The younger is submissive to the elder and the female to the male.

Physical punishment is acceptable for older children and in some cultures (Samoan and Filipino) may become excessive and injure the child.

Psychological punishments (guilt, shame) and social control are used by most cultures to discipline older children.

The purpose of this section has been to provide you preliminary information on cultural differences useful for doing family assessments. The cultural diversity within each ethnic group and the general nature of this information cannot be overemphasized. When you encounter a family whose cultural background is different from your own, it is important for you to be willing to learn and not judge the situation based on your background. Do not hesitate to consult others in the agency or community who are of the same cultural background. The importance of considering cultural differences to child welfare case assessment is the identification of resources within the cultural group or community that may be useful to families in carrying out their basic function. Not being sensitive to and knowledgeable about cultural differences might result in overreaction to the situation or overlooking a potential resource, for example, a friend or neighbor who would be more than willing to supervise a child while mother works.

Used with permission of the author, Mary K. Rodwell, Ph.D., School of Social Work, Virginia Commonwealth University. From "Recognizing Cultural Differences" as seen in *Rest A Bit* by Richard Donner; Topeka, KS: Rest A Bit of Families Together, Inc.; 1988.

| ASSIGNMENT SHEET 1 | ADVANCED RESPITE CARE<br>EMOTIONALLY DISTURBED |
|---|---|

**OBJECTIVE 3**

**Describe Appropriate Behavior Management Techniques for Emotionally Disturbed Clients**

**Name**_____ **Score**_____

**INTRODUCTION**

Case studies provide situations that you may or may not have encountered. You may never encounter some of these, but thinking about how to handle them prepares you for more types of experiences.

**DIRECTIONS**

Read the following case studies and then respond how you would handle each situation if you were a respite care provider on the case. Write your responses in the blanks.

Case Study 1

You are assigned to care for Mark, who is thirty-seven years old. His parents explain that he is usually a very active, outgoing person. Recently Mark has not wanted to go to the sheltered workshop and has been refusing invitations to go out with his friends. Mark's parents say that he has just been moping around the house and will not talk to them. You approach Mark, who is sitting with his head down, and ask him how he is. He appears sad, and states, "What difference does it make?"

How would you respond to Mark, and why?

_____

_____

_____

_____

_____

_____

_____

Case Study 2

Ann is fourteen years old. When you arrive at her home, she is very agitated and her parents, frustrated. Her mother tells you Ann has been talking about a stranger who is in her closet. After checking her closet, the mother told Ann that there was no one there. When Ann persisted with her statement, her mother told her it was silly and to forget it. Ann has been pacing the room ever since.

What would you do to help this situation?

Case Study 3

As you observe six-year-old Richard, you notice that he moves constantly and that he sits for only seconds at a time. He does not seem to be able to concentrate on anything and never finishes anything he starts. Richard's parents tell you that he will not even sit down for a meal. He keeps pacing and frequently leaves the room.

How will you provide care for Richard?

Case Study 4

When Justin was three, he was diagnosed as being autistic. Now sixteen, he acts sexually aggressive when his parents are not in the house. He masturbates in front of you and takes all his clothes off. Justin is fascinated with your hair and wants to touch it constantly.

How would you deal with this situation?

Case Study 5

Linda, a young woman of twenty-four, constantly washes her hands. She washes her hands probably twenty times a minute.

How would you care for Linda?

| ANSWERS TO ASSIGNMENT | ADVANCED RESPITE CARE EMOTIONALLY DISTURBED |
|---|---|
| **Assignment Sheet 1** | Discuss answers to these case studies and consider a variety of solutions. Do encourage problem solving, exploration of feelings, and suggested alternatives for care.<br><br>Answers may include some of the following ideas: |
| Case Study 1 | Mark may be going through a period of depression caused by the work environment, family problems, disagreements with friends, or medication requirements. Check to make sure he is receiving appropriate medical care. If Mark is on medication, find out if he is taking it regularly or if he is out of medication. If the depression continues, encourage the family to seek medical attention for Mark.<br><br>Perhaps you, as a friendly acquaintance, can let Mark know that it makes a difference to you. Start a conversation that encourages Mark to discuss his friends, activities, etc.; this may provide hints about what is causing Mark to be unhappy.<br><br>Remember that suicide may become a possibility if the depression continues. Alert the appropriate personnel about Mark's depression; do not let the situation become worse without seeking help. |
| Case Study 2 | Do not make fun of Ann or tell her she is silly, but do point out that you do not see anyone else in the room.<br><br>Engage Ann in appropriate activities that will divert her attention.<br><br>Remember to protect Ann's space and do not initiate close contact unless necessary for her safety. |
| Case Study 3 | Richard is extremely active and does not need additional stimulation. Limit his contact with rowdy friends, violent or exciting television programs, and loud music with a fast beat. |

Help Richard channel his energy into positive activities. Make sure the activities are short enough for Richard to complete; use appropriate rewards for success.

Provide nutritious finger foods that are easy to eat on the move; this will help provide food necessary for growth.

Case Study 4

Do not show a reaction to the inappropriate behaviors that Justin exhibits.

Remind Justin that masturbation and nudity are appropriate in the privacy of the bathroom or his bedroom but not in the public places in the house where other people may be.

Direct Justin to a private place when he starts the inappropriate behaviors. Check on him to ensure safety.

Use appropriate reinforcement when he acts appropriately.

Depending on *your* feelings about Justin's touching your hair, decide whether to allow it. Could touching your hair be a positive reinforcement? Could you find another similar, more suitable object for him to touch?

Case Study 5

Provide short-term activities for Linda that are productive, that allow her to be successful, and that keep her mind and hands occupied.

Find a more-acceptable activity to replace the handwashing; encourage Linda to do it instead of washing her hands so often.

| ACTIVITY SHEET 1 | ADVANCED RESPITE CARE<br>EMOTIONALLY DISTURBED |
|---|---|
| ACTIVITY 1 | **Participate in an Observation Practicum** |
| PURPOSE | To observe emotionally disturbed children in different environments and at differing stages of development. |
| INTRODUCTION | This activity will give you an opportunity to observe children and adolescents with emotional disturbances. You will observe behaviors, treatments, and the ways workers interact with clients. You will spend a total of eight hours observing. Your instructor will set up the experiences for you. |
| LOCATION | • Emotionally Disturbed classes in public schools:<br>Elementary school (1 hour)<br>Middle school (1 hour)<br>High school (1 hour)<br>• Residential treatment (2 hours)<br>• Diagnostic treatment group (2 hours)<br>• Individual treatment at a guidance center or a mental health center (1 hour) |
| DIRECTIONS | After you have completed the observations, answer the following questions. Turn in the completed activity sheet to your instructor.<br>1. How did the children or clients relate to one another?<br>_____<br>_____<br>_____<br>_____ |

2. How did the children or clients relate to the adults?

3. What different types of behavior did you observe?

4. What types of treatments did you observe?

5. Did you observe any aggressive behavior? If so, describe the action and what the caregiver did to control or reduce the behavior.

| ACTIVITY SHEET 2 | ADVANCED RESPITE CARE EMOTIONALLY DISTURBED |
|---|---|

**ACTIVITY 2**

**Participate in a Buddy-System Practicum**

**PURPOSE**

To observe firsthand how an experienced person provides care for a client with an emotional disorder.

**INTRODUCTION**

You will be teamed with a respite care worker in a variety of settings so that you can closely observe one worker's interaction with the clients at each location. You will spend a total of eight hours observing specific workers.

Not every practicum location or "buddy" will be perfect; some will be less perfect than others. While in a practicum area, however, do not criticize openly. Any questions or concerns you may have can be discussed in class with your instructor.

**LOCATION**

- Family setting (2 hours)
- School or day treatment facility (2 hours)
- Hospital or residential treatment facility (2 hours)
- Parents' Assistance Center (2 hours)

**DIRECTIONS**

Your instructor will assign you a "buddy" in each of the above areas. While on the practicum, you will observe closely what your "buddy" does in the areas of client interaction and behavior management.

After you have observed a "buddy" in each area, select one child you observed during a visit to be the focus of a report. Your report should mention the problem the child has, anything you noted about the child's behavior or mannerisms, and a description of how your "buddy" implemented one activity planned for the child.

**ACTIVITY 3** — **Participate in a Hands-On Practicum**

**PURPOSE**

To provide care for an emotionally disturbed person while in a supervised setting.

**INTRODUCTION**

This activity allows you to interact directly with clients. You will give care in a couple of settings to clients with emotional disorders. The time spent will make you more confident in your ability to care for clients. You will spend a total of six hours in direct care.

A back-up person will be available for assistance with emergency situations and to make suggestions for future interaction. Even after completing the program, you will still run into situations where you will need advice.

**LOCATION**

- Family setting (4 hours)
- Agency or program (2 hours)

  **EXAMPLES:** Day care center, school, crisis nursery, recreational program such as a Girl Scout troop, Easter Seals day camp, or Special Olympics

**DIRECTIONS**

Your instructor will assign you a specific home and agency or program. While on the practicum, note the areas you have problems with and discuss them with your backup person, supervisor, or instructor.

After you have provided care, fill out the "student observations" portion for each setting. Then ask the supervisor to discuss the experience with you and to fill out the form, verifying what you have observed.

**PART I**

**Family setting**

**STUDENT OBSERVATIONS**

1. Activities with client_____

2. Client's behavior_____

3. My responses and their effectiveness_____

4. Comments_____

**SUPERVISOR COMMENTS**

1. Student's strengths_____

2. Student's areas that need improvement_____

_____

_____

_____

3. Comments_____

_____

_____

_____

Date, time of experience_____

_____

Signature Date

**PART II**

Agency/school/program setting

**STUDENT OBSERVATIONS**

1. Activities with client_____

_____

_____

_____

2. Client's behavior_____

_____

_____

_____

3. My responses and their effectiveness_____

_____

_____

_____

4. Comments_____

_____

_____

_____

**SUPERVISOR COMMENTS**

1. Student's strengths_____

_____

_____

_____

2. Student's areas that need improvement_____

_____

_____

_____

3. Comments_____

_____

_____

_____

Date, time of experience_____

_____

Signature Date

| TEST | ADVANCED RESPITE CARE<br>EMOTIONALLY DISTURBED |
|---|---|

Name_____Score_____

**OBJECTIVE 1**

Match to their correct definitions terms associated with emotionally disturbed persons. Write the correct numbers in the blanks. Definitions continue on the next page.

1. Affect
2. Aggression
3. Behavior
4. Coping mechanisms
5. Coprolalia
6. Delusion
7. DSM III-R
8. Echolalia
9. Emotion
10. Emotionally disturbed
11. Hallucination
12. Hyperactive
13. Illusion
14. Incontinence
15. Organic
16. Phobia
17. Psychotherapy
18. Regression
19. Syndrome
20. Tic

___ a. Techniques for treating mental illness that rely on establishing communication between therapist and client

___ b. Stereotyped repetition of another person's words or phrases

___ c. An irrational fear

___ d. A sensory perception that has no external stimulus but can affect all senses

___ e. Having an abnormally high level of activity

___ f. A manual published by American Psychiatric Association that lists the official diagnostic criteria for mental disorders

___ g. Localized, involuntary movement of a muscle group, especially in the face

___ h. Pertaining to a body organ or organs

___ i. The way a person acts or performs

___ j. A false perception of an external stimulus, usually seen or heard

___ k. A fixed, unreasonable belief

___ l. Having a high degree of emotional difficulty that usually extends over a long period of time

___ m. Emotional expression; a mood

___ n. A feeling

___ o. Offensive, obscene language that is compulsive and stereotyped; usually relates to feces

___ p. Methods a person uses to deal with stress or anxiety

___ q. A combination of symptoms that occur together so commonly as to form a distinct clinical picture

___ r. Retreating to a former level of behavior

___ s. Offensive, harmful action or behavior

___ t. Inability to control the bladder or bowels

**OBJECTIVE 2**

Name characteristics of emotional disorders as presented in the following case studies.

Case Study 1

Susan, fifteen, recently gave birth to a baby girl. Susan consumed alcohol throughout her pregnancy. The doctor says that the baby has fetal alcohol syndrome.

What are the characteristics of fetal alcohol syndrome?

_____

_____

_____

_____

Case Study 2

When Jimmy was five years old, he was raped by his father. Now seven, Jimmy is suffering from post-traumatic stress syndrome.

What are the characteristics of post-traumatic stress syndrome?

_____

_____

_____

_____

Case Study 3

As a result of a car accident three years ago, Jack, aged forty-two, has an organic disorder.

What are the characteristics of an organic disorder?

Case Study 4

Six-year-old Jean has been diagnosed as having attention-deficit disorder with hyperactivity.

What are the characteristics of this disorder?

Case Study 5

Your agency just assigned you to Carol, aged fourteen. Her care plan says that she has Gilles de la Tourette's syndrome. You are not familiar with this disorder and look it up.

What are the characteristics of this disorder?

**OBJECTIVE 3**

Describe appropriate behavior management techniques for emotionally disturbed clients as presented in the following case studies.

Case Study 6

Jeremy, four, has a new baby sister. The boy was interested in the baby at first but now wets the bed, talks only in baby talk, and refuses to drink from anything except a baby bottle.

How would you provide care for Jeremy?

Case Study 7

Beth is five years old. You are told that she does not like to be touched. Her only words are phrases said to her that she repeats constantly. She is sitting in a corner of the room staring at a metal box in her hands. You notice bandages on her arms and are told that she found a pencil and repeatedly stuck it in her arm until the arm bled, requiring medical attention. Looking around the room, you find it untidy and cluttered.

How would you care for Beth?

Case Study 8

Your new client Emma is eighty-two years old, and you have been to her home three times this first week. You have noticed that Emma always gets her way. After watching her, you see that she is very manipulative. Her daughter asks you what she can do to be more aware of those times she is being manipulated.

What would you tell the daughter?

Case Study 9

Bert is fifteen. Last year he was in a motorcycle accident and has some brain damage. He is generally aggressive and difficult to handle. You think that you have developed a good relationship with Bert, and you have been alone with him on many occasions.

Today Bert comes out of the kitchen with a knife in his hand. He approaches you, saying that he is going to stab you.

What would you do?

Case Study 10

Jason is a rebellious teenager. With medication, his epilepsy had been under control for more than a year. Last week, however, he had a seizure. Since then, he has refused to go out with friends or even see his girlfriend, whom he had been dating for the past six months.

How would you deal with Jason's situation?

| ANSWERS TO TEST | ADVANCED RESPITE CARE EMOTIONALLY DISTURBED |
|---|---|

**OBJECTIVE 1**

| | |
|---|---|
| a. 17 | k. 6 |
| b. 8 | l. 10 |
| c. 16 | m. 1 |
| d. 11 | n. 9 |
| e. 12 | o. 5 |
| f. 7 | p. 4 |
| g. 20 | q. 19 |
| h. 15 | r. 18 |
| i. 3 | s. 2 |
| j. 13 | t. 14 |

**OBJECTIVE 2**

Possible applications are in parentheses. Answers should include the following points:

Case Study 1

Mental retardation, small head, hyperactivity, webbed toes and fingers, poorly developed extremities, cardiac defects

Case Study 2

Reliving the traumatic experience, avoiding thoughts about the experience (avoiding father, restless and anxious whenever the father is in the room), numbing of emotions (afraid of being touched or of any closeness), irritability, depression or anxiety (nightmares), insomnia

Case Study 3

Memory impairment, disorientation, poor thought processes; lack of affect or inappropriate affect; apathy, depression, euphoria, withdrawal, aggression, regression, hyperactivity; illusions, delusions, hallucinations, anxiety, paranoid behavior, phobias

Case Study 4

Short attention span, inability to complete tasks, impulsive acts, inability to sit still, hyperactivity, with restlessness and constant movement, requiring constant supervision

Case Study 5

Tics, facial grimaces, involuntary arm movements that can progress to movements in any part of the body, possible shouting and grunting, coprolalia, echolalia

**OBJECTIVE 3**

Suggested answers:

Case Study 6

Establish trust with Jeremy by spending frequent short periods together, directing communication toward him and calling him by name. Use a quiet tone of voice, short sentences, and language Jeremy can understand.
Keep promises.
Try to help improve the client's self-esteem.
Provide physical care as needed.
Have a structured, controlled environment with as little change in the daily routine as possible.
Let Jeremy be as independent as possible; encourage, but do not demand. Do not rush him to perform activities, but assist as needed.
Do not punish him for failures.
Encourage any improvement.

Case Study 7

Remain calm, but interupt any self-abuse (remove any objects from the environment that Beth could use for self-injury.)
Take care of Beth's physical needs and encourage her to get adequate sleep and nutrition.
Observe Beth's behavior constantly and closely; do not leave her alone for any period of time.
Assign Beth simple tasks to channel her attention and energy, if possible.
Try to improve Beth's self-esteem.
Allow Beth to express herself.
Be patient and honest with Beth, but do not be critical or show anger.
Limit body contact except as a protective measure because Beth may redirect anger and hostility toward you.

Case Study 8

Note ways that Emma tries to manipulate you.
Tell Emma that you are aware that she is using manipulative behavior.
Do not respond to manipulative behavior such as flattery, obscene jokes, or vulgar language.
Set acceptable limits and explain them to Emma; keep in mind that she will test those limits.
Be consistent, open, and honest.
Do not react with anger.

| | |
|---|---|
| Case Study 9 | (De-escalate the behavior: do not panic, be firm, keep your distance, ask Bert why he is doing this, talk him down if you can, call for backup as soon as possible.)<br>Maintain a quiet, calm, but firm approach.<br>Avoid close body contact that may intimidate or threaten Bert.<br>Set limits for behavior, and give explanations for rules and regulations.<br>Request rather than demand.<br>Allow Bert to express himself.<br>Channel the aggression into an acceptable outlet such as games, sports, etc. if possible.<br>Isolate Bert if necessary.<br>(Document the incident)<br>Use physical containment as a last resort. |
| Case Study 10 | Try to make Jason aware that his refusal to see his friends hurts himself and his friends.<br>Allow Jason to express his feelings.<br>Encourage him to tell his peers about his epilepsy. |